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ABSTRACT

Using an itinerant team of professional rehabilitation personnel, a three-year project was conducted in West Virginia to provide the older blind in three counties (Cabell, Wood, Kanawha) with comprehensive rehabilitation services in both the home and community so that they could become as independent as possible, and, if possible, obtain gainful employment. The first nine months of the project dealt primarily with development of referral sources and inservice staff training. Out of the 408 referrals provided, 133 cases received services. Fifty-nine clients were trained in mobility skills, ninety-seven chose to receive instruction in homemaking, and 114 participated in communications training. Clients were referred on an individual basis to community resources such as the Division of Vocational Rehabilitation, Goodwill Industries Homebound Program, Library Commission, and community schools. A consumer evaluation of the project showed that the clients were satisfied overall, and a majority of the professionals who had originally referred participants assessed the program favorably. It was disappointing that 128 individuals contacted refused services, and that ophthalmologists provided so few referrals. Recommendations were made for future services, including (1) hiring a third party to evaluate the program's effectiveness, (2) expanding the program to include the functionally blind, and (3) expanding and publicizing the loan of talking cassette books by libraries. (ELG)

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A PROJECT TO DEMONSTRATE THE ROLE OF A REHABILITATION TEAM IN
PROVIDING COMPREHENSIVE SERVICES TO THE OLDER LEGALLY BLIND
ON AN ITINERANT BASIS

FINAL REPORT

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West Virginia Division of Vocational Rehabilitation
Thorold S. Funk, Director

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RECOMMENDATION

The Division of Vocational Rehabilitation should provide blind adjustment training services on an itinerant basis to all eligible visually impaired citizens of West Virginia.

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CHAPTER I

PURPOSE

The estimated number of blind in West Virginia is 4,000 based on National Society for the Prevention of Blindness 1971 estimates. Of this number an estimated one-half, or 2,000 would be 55 or older. In 1975, the West Virginia Division of Vocational Rehabilitation served approximately 500 legally blind clients and only five percent of that number were the older blind. Therefore, there apparently was a large, severely disabled population, over age 55 not identified or receiving services.

The primary objective of the project was to use an itinerant team of professional rehabilitation staff to serve the older blind in three counties, providing comprehensive rehabilitation services in the home, neighborhood and community that would enable the older blind to achieve their optimum level of independent functioning, and where possible, gainful employment. Additional significant aims in the original application included:

1. To survey and identify the older blind in the three target counties who could benefit from rehabilitation services.
2. To develop and implement methods of survey and identification of the older blind that would be applicable throughout West Virginia.
3. To develop methods of evaluation in order to refer to the regular agency program those persons who demonstrated the potential and motivation for vocational services.
4. To help the older blind achieve their maximum level of independent functioning by providing instruction in mobility, personal management, homemaking, communication, social and recreational skills.
5. To provide in-service training and education to staff of other community agencies and facilities regarding the older blind and how the older blind might be integrated into the programs and services of those agencies.
6. To secure new information on the incidence of blindness in the age group 55 and older for future program planning of agency services to the older blind.

7. To assist the consumer in determining his needs beyond rehabilitation and to plan and implement the procedures he will use to meet those needs.
8. To serve exclusively the older blind (persons age 55 and older who were legally blind--blindness, both eyes with correction not more than 20/200 in better eye or limitation in field of 20 degrees), a severely disabled group who had not received the extent of services afforded other age groups of the blind.
9. To plan and implement an individualized program of rehabilitation services with the consumer that he saw as purposefully related to his life and attainable in a reasonable amount of time.

CHAPTER II

REVIEW OF LITERATURE

A review of Mary K. Bauman Annotated Listing of the Literature cites 64 references on the older blind (Bauman 1976). Twenty-one of the listed publications were dated before 1960; 14 were published between 1960 and 1969, and 29 after 1970. Topics covered were distributed into the following categories:

Vocational	3 percent
Community Services	11 percent
Government Programs and Policy	3 percent
Training	6 percent
Institutional Care	17 percent
Care, Diseases of Eye and Optical Aids	13 percent
Needs	16 percent
Recreation	9 percent
Psychological Problems	11 percent
Staff Training	3 percent
General Problems of Aging	3 percent
Deaf-Blind Communications	1.5 percent
Demographic Information	1.5 percent
Environmental Barriers	1.5 percent

Of the 29 publications dated after 1970, 14 pertained to nursing home care, eye pathology and optical aids. Of the 15 remaining, the following were available for review:

Fitch (1975), speaking at the closing session of the First National Conference on Aging and Blindness said, "We really do not have enough data or statistical records...I don't honestly believe we know the dimension of our problem...I would certainly underscore this as one of the major areas in which we ought to be taking some activity."

Dickey (1975), notes that data describing the vocational characteristics of the older blind population is not available, but a statistical overview of the occupational areas in which older persons are employed is used to make judgments about the kinds of vocational adjustments that might be appropriate.

Minkoff (1972), emphasizes the importance of individual planning, "A specific program approach is required, one that accepts each

blind person as he is--an individual who has a greater or lesser capacity to integrate." As early as 1969, Walter Bowinger, in an article in New Outlook for the Blind, stressed the necessity for an individual approach.

Disability and Rehabilitation (1971), a report of the 1971 White House Conference on Aging, designed the Special Concerns Session on Aging and Blindness to focus national attention on the special needs. Recommendations included: (1) The need to provide older blind persons with rehabilitation services; (2) Increased use of low vision aids; (3) Widespread mobility instruction; (4) Rehabilitation adjustment training, mobility instruction, etc., should be made available to all persons who need them, and not only those who are employable; (5) Rehabilitation personnel should be trained in service to the aging through specially-funded programs; and (6) Grant applications for research and demonstration projects for the older disabled person should be given high priority. The Project for the Elderly Blind was obviously a result of many of the recommendations made at that time.

Perlman (1977), reporting on the Second Mary E. Switzer Memorial Seminar indicated the Seminar focused on five major issues: (1) The impact of blindness on the aging process; (2) The role of rehabilitative personnel in their involvement with the older blind and utilization of existing community resources; (3) Services for the older blind, the benefits of specialized and integrated services; (4) Overcoming attitude and other barriers in the rehabilitation of older blind persons; and (5) The impact of federal legislation on older blind and severely visually impaired persons. Significant recommendations made in this report of particular interest to our project included: (1) Model projects have demonstrated that investment in making rehabilitation services available to the blind and visually impaired beyond age 55 have cost benefits and should be funded on a continuing basis; (2) Service delivery systems must include regional facilities; community centers, as well as services in the home in order to fully comply with Section 504 of the Rehabilitation Act of 1973; (3) A uniform policy is needed to inform prospective consumers of the service options available; (4) More rehabilitation teachers, orientation and mobility specialists and aging curricula are needed; (5) Emphasis on early recognition of visual impairment and delivery of services; and (6) Provision of available, quality low vision aids.

In 1967, a West Virginia project to demonstrate the role of a state vocational rehabilitation agency in serving the disabled aged, (Hanger 1967), showed the contribution a rehabilitation center could

make toward rehabilitating the aged (over age 55) and that services could restore the aged to physical and mental well-being and improved functioning. In addition, data was gathered about characteristics of the disabled aged population to determine the outlook for working with this group. Although the population studied was disabled elderly, not blind elderly, the following significant findings would be applicable to both groups: (1) There were many aged who adjusted to their handicap in life situations and were not interested in going through the stress and effort required to become rehabilitated; (2) The cost of services was greater; (3) Efforts toward rehabilitation were more hazardous for the aged in terms of life and health; (4) A triad of disease and disorder was often found; (5) Approximately 50 percent had positive or borderline signs of organic brain damage according to the Bender-Gestalt Test scored by the Hain method; (6) Dependency was found as a personality factor in almost 50 percent of the aged clients; (7) Energy levels were often lower in the aged client; and (9) Self-employment was the only practical employment possibility for money.

Over ten percent of the population is 65 or older, and about one-half of all those with serious eye problems are over age 65. Two of every three elderly people cite "poor vision" as their number one health problem (Dickman 1977). His emphasis was on outreach as "too many older people with serious vision problems have been conditioned to not come forward...this seeming content with non-participation and inactivity must be planned for."

The Rehabilitation Act of 1973 and the 1974 Amendments provided for funding for special projects for the older blind. Currently six special projects providing services to the elderly blind have been funded under Section 304 (b) (1) of the Act.

The Texas Project, (Texas 1977), "Development of a Pattern of Vocational Rehabilitation Services to Older Blind", is designed to deliver specialized and intensive services to older blind persons to enhance their self-reliance and independent living capabilities. Basic eligibility requirements are individuals legally blind, 55 years of age who, by reasons of the combination of disability and age, are not likely to be accepted for services by a regular vocational rehabilitation program. There are five project sites served by a staff of 30 (ten full time).

The Arkansas Project, (Arkansas 1977), "Vocational Rehabilitation Services for Older Blind Individuals", provides

services in the home, nursing home or at the Arkansas Enterprises for the Blind. In addition, orientation and training is being provided to those who work with the elderly blind in the community and nursing homes.

The Colorado Project, (Colorado 1974), "Services for the Visually Impaired Elderly Blind," is providing intensive personal adjustment training services to older blind persons in a rural target area of the State of Colorado. By the use of a mobile adjustment team and local resource personnel, they are implementing a program of concentrated diagnostic, instructional, counseling, social and recreational services with a frequency of contacts not previously possible. Basic eligibility requirements are age 55 and legal blindness. The staff includes a program coordinator, counselor, mobility instructor, two rehabilitation teacher specialists and a stenographer. The staff covers an eleven-county rural area using a mobile van equipped with kitchen facilities and other evaluative and training aids.

The Oregon Project, (Oregon 1975), "Services to the Older Blind," is designed to provide rehabilitation services to older blind persons at their place of residence throughout the State of Oregon, utilizing a mobile van. The services provided include orientation and mobility instruction, techniques of daily living and home management training, communication skill instruction, as well as counseling and informational services.

The Virginia Commission for the Visually Handicapped, Brandeis University, and the American Foundation for the Blind are working together in the development and implementation of a project designed to explore and develop innovative alternatives to the institutionalization of older visually handicapped persons, (Virginia 1976). Basic eligibility requirements are individuals age 60 or older, visually eligible for services from the Virginia Commission for the Blind and who, without certain needed community services, are in danger of becoming institutionalized.

The six reports of projects currently in progress should significantly add to the literature concerning blindness. Hopefully, these reports will lead to better definition and delivery of services and give concise statistics regarding the characteristics, requirements and capacities of the older blind population.

CHAPTER III

PROCEDURE

The project staff consisted of a rehabilitation counselor, mobility specialist, rehabilitation homemaker teacher, communications teacher and secretary. A recreation counselor was to be included in the project staff. This position was filled for three months, but this staff member resigned to train as a mobility specialist. The decision was made not to fill the position as, by that time, the staff felt this role could be assumed by the other project members. It also should be noted that the project staff members were, with the exception of the communications teacher, experienced Vocational Rehabilitation employees.

The project covered a three-county area (Cabell, Wood, Kanawha) in the West Central part of West Virginia. The area covered was approximately 800 square miles with a general population of approximately 420,000 (1970). The project offices were located in Charleston (Kanawha County).

The first nine-month segment of the project dealt primarily with development of referral sources and in-service staff training. Development of referral sources proved to be a comparatively easy matter. Public and private agencies and individuals who provide services to those over 55 with visual problems were contacted and the program explained. Also, letters and brochures (Appendix B) were developed and distributed and public service announcements on radio utilized. The response was excellent with 200 referrals received the first year.

Various methods of contacting referrals were attempted. Unfortunately, no procedure proved to be outstandingly successful (of the 275 referrals who did not receive services, 46 percent refused services). Initial contacts were attempted by telephone, in person and by letter. The one method eliminated almost immediately was going to the home without first making an appointment. The older blind person, living alone, does not readily accept a stranger at the door. If a telephone number was available, a telephone call scheduling an appointment to further explain project services was attempted. Also, appointments for the initial contact were occasionally made through the referral source. Where telephone numbers were not available, a form letter was mailed. If the letter was not answered (a self-addressed, stamped envelope was enclosed) and

there was no telephone number available, the only alternative was an initial home contact.

All referrals were initially contacted by the rehabilitation counselor. The WVDVR-77, Survey Form, was used to collect information, and a medical release form was signed. If vocational potential seemed apparent (i.e. homemakers, vending stand operators), a WVDVR-76, Application for Rehabilitation Services Form was signed. (Appendix E)

After the initial contact was made, the case was staffed, staffings being held once a week; and the decision was made for the case to follow one of three courses of action: minor services only, accepted for evaluation--project only, or accepted for evaluation--vocational potential. The following are examples of clients accepted in each category:

Minor Services Only

The client was an 86-year-old, visually impaired female, living alone in a housing project for the elderly. She continued to function as a homemaker with assistance from others. She expressed an interest in any special aids that might be of help. Evaluations by staff indicated that senility (not medically documented) precluded any training but that she might benefit from the provision of a large numbered phone dial. This was provided, and the client was able to use it. It should be noted that many clients who did not receive services because of severity of handicap or who received minor services only were unable to remember new material for any length of time, precluding the advisability of attempting a training program.

Accepted for Evaluation - Project Only

The client was an 80-year-old female with loss of vision of approximately one year's duration. She had begun to receive training services in Michigan prior to her family's moving her to West Virginia, and she was living in a nursing home when seen by Project staff. Although living in a controlled environment, she was well able to benefit from a full training program, including mobility, communication and activities of daily living.

Accepted for Evaluation - Vocational Potential

The client was a 58-year-old, diabetic, female with total blindness of the right eye and light perception only in the left eye. She was a former public health nurse.

Project services greatly increased the level of this woman's functioning in many areas. Provision of an insulin syringe-filling device enabled her to be completely independent in taking insulin. She was provided a Braille alarm clock, Braille timer and an automatic needle threader. She learned to cook and to bake again. She applied Braille labels to spices and packaged foods and made a Braille cookbook of her own favorite recipes. Her laundry equipment controls were marked for tactual selection of cycles. Living in a small trailer court with unpaved streets and uneven terrain, there were no sharply definable shorelines or guidelines, and orientation had to be maintained by attending to very subtle and indistinct audible cues. The client had not walked alone in the out-of-doors for a number of years, and was able to learn to use these cues to travel safely to a small grocery store. In the area of communications, she received a Marks Handwriting Guide and signature guide which enabled her to handle all of her personal and business correspondence. She learned to operate a tape recorder and tape player which she obtained for use in taking courses from the Hadley School for the Blind. The client learned Braille through Grade II and was provided pocket and desk slates for use in writing recipes, phone numbers, etc. She was provided a Braille deck of playing cards and received a typewriter and typing instruction. This client obviously was able to benefit from a full training program and exhibited vocational potential. She is now functioning at her optimum level as a homemaker.

Also, upon initial contact, appointments were made for medical examinations for clients or recent abstracts were obtained, where indicated, including visual, hearing and general medical information. (Table I)

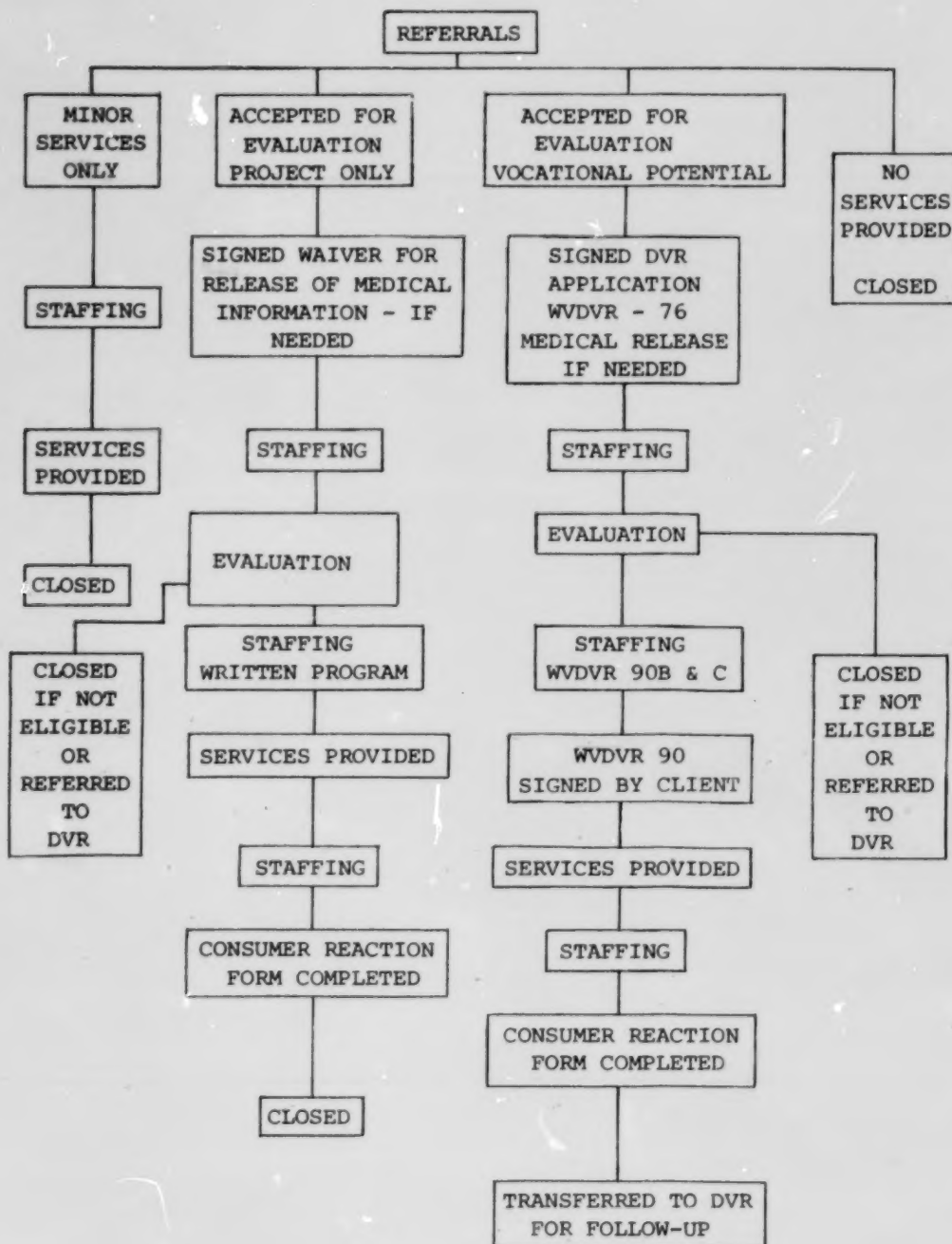
When evaluations were completed in the three teaching areas, the case was again staffed and the program of instruction for each individual client written out. In the case of those with vocational potential, WVDVR-90, 90B and 90C were completed. (Appendix E)

The weekly staffings were an important part of the delivery of services. Not only did these meetings serve for discussion of problems and the planning of individual programs, staffings were vital to the smooth delivery system that was achieved. Following staffing, the project team members were able to plan their programs for the next week and to schedule appointments for either evaluations of new clients or resumption of regular weekly teaching.

When all services were completed, the case was again staffed and results compared with the original outline. If there were any additions or deletions from the originally-planned program, these were noted. WVDVR-99, Case Development Log, (Appendix E) was used throughout for summaries of all contacts with clients and for staffing notes. A consumer reaction form (Appendix C) was completed by all clients, usually within a month after the completion of training services. Those cases having vocational potential were transferred to the Vocational Rehabilitation Office in the appropriate area for follow-up services upon completion of project services.

The normal vocational rehabilitation process, using standard West Virginia Division of Vocational Rehabilitation forms and case-work guidelines, generally allowed for efficient provision of services within a structure that also allowed for accountability.

TABLE I
FLOW CHART



CHAPTER IV

STATISTICAL DATA

Three of the specific aims listed in the original project proposal dealt with demographic information: (1) To survey and identify the older blind in the three target counties who can benefit from rehabilitation services; (2) To develop and implement methods of survey and identification of the older blind that will be applicable throughout West Virginia; and (3) To secure new information on the incidence of blindness in the age group 55 and older for future program planning of agency services to the older blind. The WVDVR-77, Survey Form, (Appendix E) in conjunction with a project data collection form (Appendix D) was completed on the 133 clients who received services. In addition, five items on the project data collection form were completed for the remaining 275 cases.

Thirty-three percent of the clients referred to the project received services. (Table 2). The remaining 67 percent either refused services, were not legally blind, did not live in the three-county area served by the project or had died between the time of referral and time of contact. Also, in 12 percent of the cases closed, it was felt the handicap was too severe to benefit from a training program. In such cases, either the referral was totally bed-ridden or their communication skills and/or memory were too poor for a teaching program to be of any assistance. The project staff was unable to locate 15 persons or six percent of the referrals. In each case, the referral source was contacted for updated addresses, but they were unavailable.

The typical client was found to be a 72-year-old white, widowed, female living alone in an urban area, currently a homemaker and with a work history of homemaker or a semi-skilled job and an educational background between the 7th to 11th grade. She had a telephone, received Social Security benefits, was on Medicare, had no previous vocational rehabilitation experience, no consumer involvement, was partially blind due to macular degeneration and had a secondary disability, most likely a cardiac condition, diabetes or hearing loss.

TABLE 2

REASON FOR CLOSURE

Category	Number	Percent
<u>Cases Closed - Received Services</u>	103	
<u>Cases Closed - Received Minor Services</u>	30	
<u>Total Cases Closed - Received Services</u>	133	33
<u>Cases Closed From Referral</u>	275	67
<u>Total Referrals</u>	408	100
<u>Reason for Closure From Referral</u>		
Handicap too Severe	34	12
Refused Services	128	46
Not Eligible	80	29
Not Age 55	(14)	(5)
Not Legally Blind	(55)	(20)
Not in Three County Area	(11)	(4)
Unable to Locate	15	6
Death	18	7

TABLE 3

DISTRIBUTION OF 133 CLIENTS RECEIVING
SERVICES BY SEX, RACE, MARITAL
STATUS, EDUCATION, LOCATION
AND LIVING ARRANGEMENT

Characteristic	Percent
<u>Sex</u>	
Male	33
Female	67
<u>Race</u>	
White	89
Negro	11
Indian	0
Other	0
<u>Marital Status</u>	
Married	37
Widowed	42
Divorced	7
Separated	2
Never Married	12
<u>Education</u>	
1st - 6th Grade	28
7th - 11th Grade	29
High School Diploma	20
College	14
College Degree	9
None	0
<u>Location</u>	
Urban	85
Rural Accessible	14
Rural Inaccessible	1
<u>Living Arrangement</u>	
Alone	45
With Spouse	38
With Family Member	10
With Non-Family Member	2
Controlled Environment (Nursing Home)	5

TABLE 4

DISTRIBUTION OF 133 CLIENTS RECEIVING SERVICES BY
FINANCIAL SUPPORT, WORK HISTORY, CURRENT EMPLOYMENT
DIVISION OF VOCATIONAL REHABILITATION EXPERIENCE
CONSUMER INVOLVEMENT AND TELEPHONE AVAILABLE

Characteristic	Percent
<u>Financial Support</u>	
SSDI	8
SS	45
SSI	12
SSI & SS	10
Family & Friends	9
Other	16
<u>Work History</u>	
Homemaker	20
Unskilled	13
Semiskilled	23
Skilled	18
Professional	18
Vending Stand	6
None	2
<u>Current Employment</u>	
Homemaker	60
Unskilled	0
Semiskilled	1
Skilled	1.5
Professional	1.5
Vending Stand	4
None	32
<u>Previous DVR Experience</u>	
Yes	37
No	63
<u>Consumer Involvement</u>	
Yes	18
No	82
<u>Telephone</u>	
Yes	98
No	2

Several of the characteristics in Tables 3 and 4 deserve further clarification. The small percentage of blacks reflects the state population. The very small number of divorced and separated is probably to be expected in the age group which the project served. The educational background was somewhat higher than the project staff expected to find considering the age group. A full explanation of location and definition of terms urban, rural accessible and rural inaccessible is found in Chapter VI. The item "other", under financial support, refers to those who received incomes in addition to Social Security, i.e. pensions, real estate, stocks, bonds, savings, etc. The item "current employment" is also discussed in Chapter VI; the term "consumer involvement" refers to those clients who were members of the Federation of the Blind. The telephone for many of the clients was their major source of recreation and socialization. Only three clients who received services did not have phones and they were living in controlled environments. The remaining three living in a controlled environment had private phones.

TABLE 5

DISTRIBUTION OF 133 CLIENTS RECEIVING SERVICES BY
EXTENT OF BLINDNESS, CAUSE OF VISUAL PROBLEM
ONSET AGE AND SECONDARY DISABILITY

Characteristic	Percent
<u>Extent of Blindness</u>	
Total	32
Partial	68
<u>Onset Age</u>	
0-1	8
2-25	11
26-40	8
41-50	3
51-60	17
Over 60	53

TABLE 5 (Continued)

Characteristic	Percent
<u>Cause of Visual Problem</u>	
Cataract	12
Glaucoma	14
Diabetic Retinopathy	13
Macular Degeneration	26
Retinitis Pigmentosa	4
Corneal Disease and Degenerative Conditions	1
Detached Retina	5
Other Infectious Degenerative Diseases	5
Congenital Malformation	4
Accident, Poisoning, Exposure, Injury	11
Ill-Defined and Unspecified Causes	5
<u>Secondary Disability</u>	
Cardiac Conditions	16
Diabetes	14
Hearing Loss	13
Arthritis	7
Psychoneurotic	4
Respiratory	4
Stroke	3
Malignant Neoplasms	2
Urinary System	2
Polio	2
Disorders of Nervous System	2
Amputation	1
Mental Retardation	1
Colostomy	1
Varicose Veins	1
Speech	1
None	24
Not Available	2

Little information was available regarding the 275 cases closed from referral. (Table 6). The average age, where this information was obtained, was 72. The ratio of male to female was nearly the same as the ratio of those receiving services. Location of home and availability of telephone also seem similar to the data for the 133 cases receiving services with the exception of those cases for which the data was not available.

TABLE 6

DISTRIBUTION OF 275 CASES CLOSED FROM REFERRAL BY
SEX, LOCATION OF HOME AND TELEPHONE AVAILABLE

Characteristic	Percent
<u>Sex</u>	
Male	35
Female	65
<u>Location of Home</u>	
Urban	79
Rural Accessible	8
Rural Inaccessible	1
Not Available	12
<u>Telephone</u>	
Yes	75
No	8
Not Available	17

CHAPTER V

INDIVIDUAL REPORTS

MOBILITY

Procedures

Mobility services were available to all clients contacted by the project. Those who refused project services, in doing so, refused mobility training as well. All cases accepted by the project for any type of service were evaluated by the orientation and mobility specialist for inclusion in the mobility part of the program. The usual course of events was for the project coordinator, who interviewed the client originally, to note in staffing whether or not the client had mobility potential. In some instances, senility and other physical limitations were so severe that orientation and mobility training was not feasible from the very beginning. However, most referrals were interviewed directly by the mobility specialist.

The purpose of the first meeting was to acquaint the client, when necessary, with the fact that mobility was still possible despite visual problems. An assessment of the client's current orientation and mobility skills was made by interview, together with a cursory evaluation of any remaining vision. Secondary disabilities and their relation to current functioning were discussed along with the client's personal appraisal of his desired level of activity. At this point, the client would decide whether or not he could benefit from the program. This decision was usually made by the client. Experience found success more likely when motivation was high, and motivation was higher when the decision and limits of service were set by the client himself or herself. Before the interview was completed, general mobility goals were established and a rough time frame for provision and completion of services was estimated. The mobility specialist returned to relay the results of the interview in staffing so that more formal notations could be entered into the case. If the client was to receive mobility training, appropriate entries were made on the Mobility Instructional Checklist and Rating Form. (Appendix D).

Many of those evaluated for mobility services did not receive training for various reasons. This was true in this project area

more than other areas because of the nature of the discipline. Of the 103 clients evaluated for mobility, 44 were not trained, and of these, 23 percent had physical or mental limitations that precluded instruction. Twenty-three percent had adequate skill (or vision) for their current and foreseeable needs. Two persons received no training for reasons related to scheduling and weather. Refusal was, however, the main reason for not providing training and accounted for 50 percent of the non-service cases in the mobility section. Reasons for refusal will be discussed later in more detail.

Scheduling clients was, from the beginning, a complicated task since clients were seen in three separate counties, separated by one or more counties. Three service model options were available. The first was to see each client on a once per week basis, keeping the total number of active clients at a level such that everyone could be seen once a week. Second, was the possibility of working one county per week and providing intensive service in that county and then moving on to another county. In this instance, there would be periods of intensive training for each client followed by two weeks with none. The third possibility was to provide some combination of the first two methods whereby some clients could be seen daily and some weekly.

All three options posed problems, and it was finally decided to schedule on a once per week basis, despite the fact that without reinforcement new skills would weaken between visits. The effectiveness of working in one area with one group of clients for an entire week would necessitate having either a great many clients ready at the same time or having clients with the stamina and ability to profit by two to three hours instruction per day. Even so, one client's illness could produce a potentially unfillable block of time amounting to perhaps ten hours per week. One week of bad weather could devastate the schedule. In addition, limited travel expense funds would be depleted more rapidly with the staff utilizing motels throughout the week.

The length of individual classes varied from 20 minutes to a maximum of three hours, depending on the client's individual needs, physical stamina, and ability to profit by instruction. On the average, 7.29 hours were spent with each client. Some clients required only one hour's instruction, perhaps in basic indoor safety techniques or human guide. The maximum time spent with any one client was 20 hours.

Results

Results were tabulated by studying the entries on the Mobility Instructional Checklist and Rating Form. This form divided mobility into ten different skill blocks:

- Human Guide
- Familiar Indoor Areas (without cane)
- Diagonal Cane Technique
- Touch Technique
- Residential Sidewalks
- Business Area Travel
- Non-Sidewalk Travel
- Residential Area Travel
- Light Controlled Intersections
- Stop-Sign Controlled Intersections

When training was provided, each skill block was given an initial rating from one through four as per the description of level of skill noted on the form. After training was provided, a Post-Instructional Rating was given and the degree of improvement noted. In order to avoid the difficulties imposed by the fact that not all clients received training in the same skills, distinction was made between "Initial Evaluation Rating" and "Pre-Instruction Rating." The rating was the same, but the different categories prevented skills not taught being averaged in as no improvement shown.

Figure 1 reveals the percentage of times each skill rating was applied on initial evaluation. This information can be seen as reflecting the compiled mobility skill of clients seen on initial evaluation. However, as indicated previously, the initial evaluation figures were collected only when at least a portion of training was eventually completed. The Initial Evaluation Rating figures do not reflect the skill, or lack of it, of those who were bedfast or those who refused all mobility services completely:

" 3

Figures 2 and 3 identify those skills where intervention was applied so that Pre-Instruction and Post-Instruction ratings could be compared. The percentages refer to the number of times a given rating was applied to the skill taught.

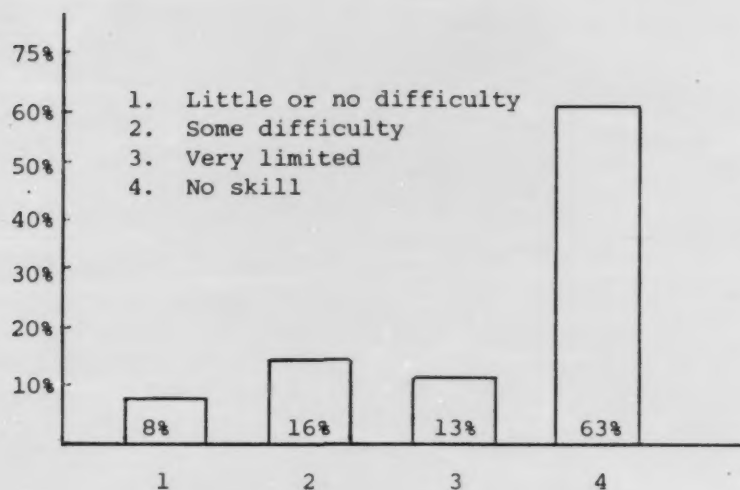


Figure 1 - INITIAL EVALUATION - Percentage of instances where a given rating was applied to mobility skills

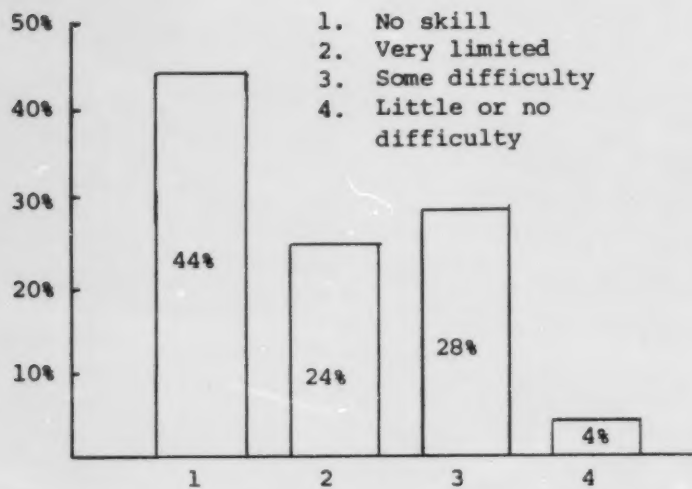


Figure 2 - PRE-INSTRUCTION - Percentage of instances where given ratings were applied to skills

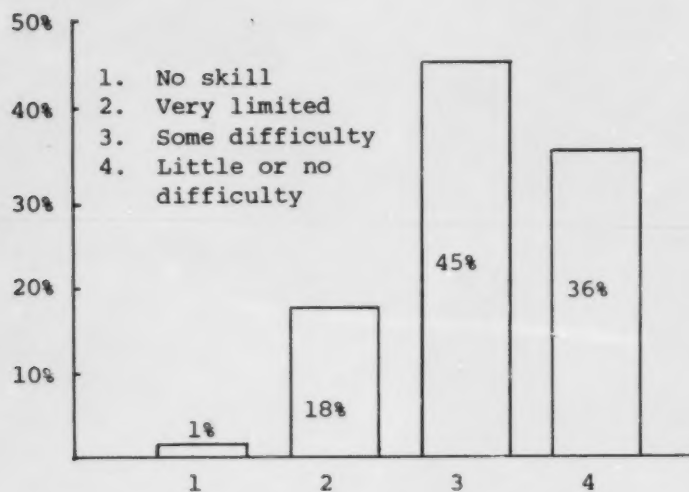


Figure 3 - POST-INSTRUCTION - Percentage of instances where given ratings were applied to skills

It is readily apparent from Figures 1, 2, and 3 that most clients had relatively few mobility skills at the initiation of the project. After completion of services 90 percent of the clients showed improvement in the skills taught. Only five individuals showed no improvement. Of these, one refused services just after beginning training and the remainder were physically or mentally unable to cope with the instructions. The average improvement was by one point on the four point rating scale. Some individuals improved as much as three points.

Another method is available for describing the level of skill shown by clients prior to instruction. A Mobility Interview Form (See Appendix) was used as a matter of convenience for the mobility specialist in planning for 101 of the evaluations. This number included some clients for whom no training was eventually provided. The extent of travel reported by those clients on initial evaluation has been compressed as follows:

INDOOR

1. Travels own home and homes of immediate family only
40 percent.
2. Travels own home and some familiar areas (church,
doctor's office) 32 percent.
3. Travels indoors freely (with and without travel
vision) 28 percent.

OUTDOOR

- | | |
|--|-----|
| 1. No travel outdoors | 32% |
| 2. One or two short familiar routes outdoors | 28% |
| 3. Many familiar routes | 19% |
| 4. Freely (with vision) | 18% |
| 5. Freely (without vision) | 3% |

As noted previously, the clients decided for the most part what skills they thought would be valuable for them. Only human guide training was provided as a matter of course to those who had no specific method for the use of a sighted guide or who used some unsafe method. Following is a list of the mobility skills in the order in which they were most frequently taught:

1. Human Guide - 77%
2. Touch Technique - 69%
3. Familiar Indoor Areas - 58%
4. Residential Sidewalks - 48%
5. Stop-Sign Controlled Intersection - 40%
6. Residential Areas Travel - 31%
7. Non-Sidewalk Travel - 29%
8. Light Controlled Intersection - 27%
9. Diagonal Cane Technique - 23%
10. Business Area Travel - 13%

The fact that business areas is at the bottom of the list is significant. Although it was found that the elderly blind tended to live closely about the urban areas in the State, presumably to be closer to services, they did not often use the business areas of town. Friends or relatives often acted as their agents in town, but they themselves seemed to go there infrequently. There was little interest in learning downtown areas even by those who had the physical capabilities of traveling there. The staff also noted little interest on the part of the elderly blind to become independent to the point they wished to "tackle" highly public places alone. They showed the normal fears of unknown dangers associated with the blindness itself, but these were compounded by problems of old age which made the client more vulnerable to falls, confusion, being lost and getting trampled or pushed aside in the shuffle. The elderly whom the project served were more interested in travel that would enable them to get outside for exercise, travel to nearby small businesses and services, travel to neighbors' homes or churches and other general non-threatening areas.

Many standard mobility techniques were modified to suit the elderly blind since the skills were most generally taught in situations in which they would be utilized. Modifications were freely employed to allow the client to accomplish his objective safely, but with minimum effort. In some instances, it appeared unlikely that the skills would be used in areas in which they were not taught. In these cases, allowances were made for what would be called "sloppy techniques" for more independent travelers.

Learning route travel was by far more popular than independent travel. The travel needs of individual elderly clients were particularly set and predictable. Any excursions from the predicted routine always included a friend or relative who would serve as a sighted guide.

Perceived need to travel was apparently the most important predictor of success in the mobility program. There were no significant correlations between success and education, age, social and economic status, or even the complexity of the mobility skill to be mastered. When the client looked on the mobility class as a type of useful recreation, they were more prone to want to continue in the program and improve their skill. Some clients particularly enjoyed being in a school situation again, and playing the role of pupil kept their interest high. Those who attempted to maintain an older, therefore wiser, attitude lost interest more quickly and did not do as well.

Problems

A number of problems were associated with working exclusively with the elderly blind. The major problem was that caused by the influence of other secondary disabilities associated with advancing age. Senility, for example, was a problem in some cases; but even when that diagnosis was not clear there was a reduction in mental sharpness which hindered training scheduled only on a once per week basis. A certain amount of material was forgotten or distorted in a week's time, but in some extreme cases so was the identity of the instructor.

Painful ambulation, caused by anything from arthritis to poor physical condition, ranked as the second major hinderance to training. Endurance levels were often incredibly low for individuals who had been totally inactive for years. Not only did these people have to deal with blindness and immobility, but with the resumption of physical activity as well. It was interesting to note the preparation involved in going outside for a number of clients. Planning, dressing up, avoiding other activities that same date, all evidenced the fact that going out was an unusual activity. Susceptibility to injury was usually an increased concern to the older blind and justifiably so given the fact that injuries, especially broken bones require longer to heal with age.

Weather conditions became a major deterrent to a smooth mobility training program. Mobility itself was often something of an uncomfortable experience for many people and the added discomfort of rain, heat, snow or cold caused many cancellations. Since many in this age group did not usually travel under these circumstances anyway, they were not pressed to learn in the adverse conditions. Susceptibility to cold, falls on ice, cardiac conditions and other considerations supported the decision to

allow the client major charge of his own pace in learning. Poor weather was one of the main reasons the average client required in excess of three months to get in eight hours of class time. Having comfortable conditions was very important to elderly trainees who frequently viewed the lesson as a social occasion. Those conditions that would cancel a picnic would frequently cancel a class.

Cancellations would possibly not have been such a problem in a residential rehabilitation center setting despite the age of trainees. However, when working with clients at or near their homes, they often take the position of being "employer" and are less likely to put themselves out. Although clients were encouraged to be actively involved in planning their own programs, some accepted suggestions less readily than others.

Occasionally, families living with or near the blind person reinforced dependency and made attempts to undermine the independence the client was slowly gaining. When the relative lived in the same household it was a matter of tactfully bringing up the subject and discussing the fears and concerns for the older person. More often, relatives and friends lived outside the home and the client was caught in the middle, desiring increased independence on one hand and over-cautioned by well-meaning friends and relatives on the other.

Frequently, the motivation for mobility instruction was linked with having a friendly visitor. The rapport established, by allowing this conception was necessary, but in some cases it was evident that having the visitor was more important to the person than having the lesson. The lesson appeared at times to simply be a vehicle for friendly exchange, a need many elderly blind found difficult to fulfill. Usually, the client benefited from instruction, but some humored the instructor with no real intention of following through on skills.

Following through on new skills was especially difficult for those who, over a period of years, had learned other ways of coping with difficulties of orientation mobility. When the older ways were unsafe or inefficient, the instructor attempted to make suggestions for improvement. Although the client was usually receptive to suggestions, force of habit and the pain of change often sent him back to older ways without giving the newer method a fair try.

As mentioned earlier, refusal of all mobility training was a frequent occurrence in this age group. Reasons for refusal were varied. Some simply felt no need to travel independently. The only walking necessary for them was to go from home to a car or taxi; and since they did not drive, someone else was always along to assist. Whenever "family" was available, "family" had taken over many of the "chores" of the elderly so that going out was unnecessary. Clients varied in their enjoyment of this type of arrangement, but often were content to let things remain that way. Occasionally, partially sighted clients refused mobility because of feelings they had about themselves as sighted persons and about being seen with the cane. Despite their restricted mobility, they did not want training because accepting it would be to admit blindness. At times it was difficult to change these attitudes.

Recommendations

The Elderly Blind Project was one of the first instances in West Virginia where orientation and mobility training was provided exclusively in the field as opposed to in a rehabilitation center setting. The fact that only older clients were involved demonstrates some of the more valuable facets of this approach.

First, providing training in the field reduced the need for clients to generalize skills to their own home areas. Since the travel of the elderly blind was often restricted because of limited needs, secondary disabilities, etc., there was no need to provide them with a storehouse of mobility skills and "tricks" from which they could draw to meet ever variable conditions. Since the only skills taught them were those which they would use on a daily basis, the length of time necessary to bring them to adequate levels of functioning was relatively short. Realizing that memory for recent events is often impaired with age, it would have been unrealistic to expect the clients to maintain skills which they may use only once or twice.

Provision of training in the field also allowed for professionally assisted modifications of technique where necessary to enable clients to accomplish their objectives in the safest and easiest way possible. Certain distortions of correct technique would be allowed when the skill was to be used only in a limited area. Unsafe modifications made by the client would be corrected immediately. Similarly, orientation to new areas could be done by a professional

rather than relying upon the client's ability and initiative to explore. Occasionally, it was necessary to modify the environment slightly to provide landmarks, remove unsafe obstacles in the home, or to provide tactual information. This type of modification would have been impossible from a rehabilitation center setting.

A great deal of time teaching an individual to be an independent traveler was spent in teaching him how to handle new and unfamiliar situations on his own. This type of teaching was often unnecessary because of the lack of potentially unfamiliar circumstances to be encountered in the lives of many elderly blind. The orientation and mobility specialist was able to individualize training to an extent not possible in a rehabilitation center.

There appears to be no particular reason for a community mobility specialist to concentrate solely on the needs of the elderly blind. The skills required to work with the elderly did not seem so specialized that a competent orientation and mobility instructor could not handle them. Furthermore, concentrating solely on the elderly would probably not be productive in terms of numbers so as to eliminate traveling an exceptionally wide area in West Virginia to secure enough cases to maintain a full caseload.

The needs of a number of the older blind clients served by the project may not have required the skills of a fully trained orientation and mobility specialist. The education of others in agencies who work with the aged in such areas as human guide and indoor travel without the cane would be helpful. Referral to a mobility specialist could then be made in instances where the needs of the older person justified the service.

Increased public awareness of "what to do when you meet a blind person" and the potentials of independence for the blind would go far toward helping families to encourage independence when their members begin to lose sight.

In addition, care should be taken to achieve the correct balance between fluidity and structure in mobility programs for the elderly and for those people of all ages taught in the field. Too much of a structured program could eliminate the advantages of providing instruction in the field and too little structure could result in decreased motivation and lowered goals.

HOMEMAKING

Procedures

Following determination by the project coordinator of a client's eligibility for project services, the activities of daily living-homemaking teacher scheduled an appointment to meet with the client in his place of residence to explain this area of service and to evaluate individual client needs and interests in this area. Initial evaluative data was gathered through informal discussion aimed at eliciting how the individual's particular visual impairment affected his ability to function satisfactorily in performing activities of daily living and homemaking tasks, and by noting pre-instruction skill levels on the Activities of Daily Living-Homemaking Checklist of Instructional Needs Form (Appendix D). Of the 121 individuals evaluated, 97 (80 percent) elected to receive instruction. The remaining 20 percent either refused, were functioning adequately for their own needs or were physically and/or mentally unable to participate in a training program.

The teacher was often in disagreement with a client's refusal of instruction; however, the value of the client's active participation in decision-making related to his own future pursuits was an important consideration. Too often the elderly had little or no say in the course of events in their own lives.

For those individuals choosing to receive instruction, the checklist served as a guide or individual lesson plan. In many cases, the originally expressed needs were added to when initial hesitancy was overcome by successful completion of a single goal or when reacquisition of a skill created a need for another skill; for example, in several cases, regaining ability to cook and learning Braille led to preparation of a Braille recipe book.

As far as possible, lessons held were on a weekly basis for the duration of each client's training program. Several factors had to be taken into consideration when scheduling appointments, not the least of which was the fact that many clients were receiving mobility and communication services concurrent with activities of daily living and homemaking. It proved helpful to both client and teacher when a regular appointment could be arranged for the same hour and day of each week.

In the effort to resume an accustomed way of life, self-confidence and self-respect are essential. Advanced years, coupled with visual loss, often seriously reduces these healthy personality components. Bearing this in mind, with few exceptions, introduction of a relatively simple adaptive aid or skill constituted the client's first lesson. Mastery of a new skill, regardless of degree of complication, served to build self-confidence, to heighten interest in efforts to increase independence and to enhance trust in the client-teacher relationship.

In almost every instance, a minimum of one adaptive aid and instruction in its use were provided. Braille watches and alarm clocks, automatic needle threaders, plastic miniature foods for labeling and 60-minute timers proved to be the most popular items. Adaptive equipment was purchased in quantity and distributed as individual needs dictated, thereby eliminating the inevitable delay and paperwork involved in single purchases.

Involvement of family members in the client's training was solicited. In order to facilitate encouragement of and assistance with application of new skills between lessons, correct use of aids and new skills were demonstrated and counseling toward acceptance of a more capable, less dependent blind person was offered.

In each case, the training proceeded at a rate consistent with the client's capabilities and desires. An individual's training in this area ceased only after all planned services had been provided and client and teacher were in agreement that no further instruction was desired or indicated. The average number of hours spent instructing clients in activities of daily living and home-making was five and one-half hours. Actual time ranged from one hour to 85 hours. Average months was 2.2 with a range of from one to 16 months.

Results

For reporting purposes the activities of daily living-home-making area has been divided into the following broad skill areas:

- (1) Personal care and grooming; (2) Eating skills; (3) Laundry;
- (4) Housecleaning; (5) Knowledge of nutrition; (6) Food preparation;
- (7) Needle threading and mending; (8) Money identification; and
- (9) Use of time pieces.

The largest percentage of clients accepted and received training in food preparation (53%), needle threading and mending

(50%), use of time pieces (47%), money identification (40%) and eating skills (26%). Of importance to fewer elderly blind individuals served by this project were laundry (16%), nutrition (6%), personal care and grooming (6%) and housecleaning (1.6%).

It must be kept in mind that these figures represent only those clients who were willing to receive training in a particular skill. It would be erroneous to assume that the remainder were able to function adequately. Only one-half of the clients evaluated reported having no difficulty performing housecleaning tasks. Yet only 1.6 percent of the other half agreed to receive instruction. The 48.4 percent having limited or no skill in completion of this task received no training due to refusal (usually because the need was being met by someone else), due to physical limitations that prevented this activity or lack of need, such as in nursing home residence. Five clients received housecleaning services from Welfare paid chore workers, two from tenant services and one from a senior citizens group.

An even greater number of elderly blind individuals experienced difficulty doing laundry. However, this need was being met by purchase of laundry services, washing clothing by hand or reliance upon family members.

The majority of clients (85 percent) were found to have no problems with personal care and grooming. Some needed assistance with organization of storage and identification of clothing. Two individuals received instruction in washing and setting hair and only one requested lessons in make-up application.

Knowledge of nutrition, specifically the understanding of therapeutic diets, was found to be lacking in only a small number (19) of clients. Most of these individuals welcomed dietary counseling. In several cases, a cassette recording of the individual's therapeutic diet was prepared for his future reference. Physicians seldom realize that an inkprint diet had no practical value to an elderly blind person living alone. Their often hurried advice to follow a certain diet does not include a discussion of the reasons and methods for strict adherence. Also, some elderly individuals can learn new information only with repetition.

Embarrassment because of awkward eating skills had caused some elderly blind individuals to refuse invitations to meals in homes and restaurants. This contributed to an already serious

problem of loneliness and social isolation. One woman chose to eat her meals alone in her nursing home room prior to receiving project services. She learned to eat neatly and in a relaxed manner and was able to join the other residents at meal time. Another woman accepted training in this area, and as a result of her increased skill, accepted an invitation to a holiday meal with friends--her first shared meal since losing her vision four years ago. Of course, there were a number of people who lacked eating skills to some degree who would not accept assistance.

Fifty-two percent of clients evaluated had difficulty differentiating coins and lacked a system for identifying currency in their wallets. In most instances, these individuals had to trust strangers when making an exchange of money or had to rely upon a spouse or other family member to perform this relatively simple, yet important, skill. Of the 63 individuals who needed instruction, 49 accepted training and were successful. Three persons were mentally unable to learn this skill; the remainder preferred to cling to dependency.

The problem of telling time was alleviated for most clients by providing Braille watches or adapted alarm clocks purchased from American Foundation for the Blind. Of the 69 individuals who had no way to tell time, 56 learned to use an adapted device. For seven individuals, the ability to tell time lacked meaning.

Evaluation revealed that only 14 individuals had no problem threading a needle or mending. One hundred one were totally unable to complete this task. Of the 61 who desired this training, 55 were able to learn to use the Hexe automatic needle threader and to do simple hand sewing. One woman was depressed because of her loss of ability to hem dresses, sew on buttons and otherwise mend her clothing. She regained her skills along with a significant elevation in self-esteem.

Instruction in at least some facet of food preparation was undertaken by the greatest number of clients. Refusal to accept training for the most part stemmed from extreme fear of danger or lack of perceived need because someone else was providing this service. Most people needed to have their range controls marked so temperature settings could be tactually read. Safety techniques were taught to all clients receiving food preparation training. Methods of labeling packaged foods were needed by the majority. Those who learned Braille were assisted in making Braille labels;

others were provided plastic alphabet letters and food miniatures. Where applicable, individuals were given assistance in preparation of Braille recipes of their own choosing. Others preferred to have their favorite recipes recorded on cassettes or to have them written in large print using a black felt pen.

Individual training ran the gamut from provision of a needle threader as the only service to a course of instruction that included all nine broad areas. The effect of training upon those individuals who elected to receive only minimal assistance was to them perhaps as meaningful as the benefits derived by those who needed and wanted broader training. The importance of individual values cannot be denied in any assessment of results.

Problems concomitant with advancing years played a major role in determining the degree of interest a client possessed. Many elderly people have a minimum amount of interest in activities that are perhaps more meaningful to younger persons. Many lack the initiative, drive, ambition and aptitude to enter into an intensive training program. In this project, the clients who took advantage of multiple skill training were those in the 55-68 year-old range. Living arrangement, whether alone or with family, also was an important determinant of a client's level of interest in services. The value an individual placed upon personal independence constituted yet another determining factor. Some older people did not value independence because it would lead to further isolation if others were no longer needed to come in and help. These people actually want to depend upon someone.

Problems

The most pervasive and serious problem encountered in working with the elderly blind was one of client's lack of motivation to decrease dependence upon others through knowledge of and application of new skills. Some individuals initially pretended great interest and enthusiasm in receiving project services. It soon became apparent their genuine interest lay in having someone to show a personal concern for them and to talk to them. Instruction served as a means to this end and was not very beneficial in terms of increasing independence. Other individuals professed a desire to learn adaptive techniques for performing daily tasks yet demonstrated an unwillingness to complete homework assignments or to apply new knowledge. In this same category were those persons who repeatedly made excuses for not being able to keep regular scheduled appointments. There were yet other individuals who had

so resigned themselves to a dependent life style that they lacked the motivation to learn how to tell time using a Braille wrist watch or alarm clock.

Perhaps part of the motivational problem stems from the built-in circumstances of project services: In a client's home, he dictates to a large extent what takes place relative to training efforts. In an institutional setting the clients have demonstrated a degree of positive motivation by virtue of their being there and the staff can exercise more authority than in a home setting.

The homemaking instructor had anticipated assisting numerous individuals to regain ability to perform activities which they had felt unable to continue doing after onset of their visual loss; however, many people were found to have devised a suitable technique for themselves or to have developed an attitude of hopelessness wherein they regarded resumption of such tasks as impossible. A surprising number of clients stated "I can't do that. I'm blind."

Problems of less consequence were experienced with regard to adaptive aids. Some of the clients who have learned Braille for labeling purposes have learned large dot Braille due to impaired tactile ability. There appeared to be no single-line, large dot, Braille slates available. Single line slates are most effective for making labels on Dymo tape, Labelon tape and other plastic labeling strips. This problem was somewhat relieved by using plastic sheets which fit a standard large dot slate and then cutting the prepared labels into strips. X-ray film was tried, but proved to be too stiff requiring excessive pressure on the stylus in order to make an impression.

Several clients had difficulty learning to use standard men's and ladies' Braille wrist watches. A combination of impaired tactile sense, decrease in mental acuity, small watch hands and small raised dots rendered this time instrument impossible for some to use. Several clients suggested that one of the watch hands be constructed of a rough material to assist in easier distinction between minute and hour hands and that dots be eliminated. Braille alarm clocks proved suitable for those clients who could not use the watches; however, they were not as ideal because they could not be worn.

Recommendations

Blind adjustment skills should be made available on an itinerant basis to blind individuals of all ages. Delivery of services to an

individual's home had the advantages of relevance, adaptation of the immediate environment, and family counseling toward rehabilitation. For the majority of elderly blind persons, no training opportunities will be utilized unless they are delivered to the home.

That the elderly blind individual needs and desires adjustment training has been clearly pointed out. The simpler needs of a number of elderly blind individuals could be met if staff of agencies serving them were aware of the availability of adaptive devices, their correct use and how to teach people to use the aids. Qualified counselors and home economists are also needed to train those individuals requiring a number of more difficult skills.

Loneliness is an inherent part of the human condition and is often intensified with advancing years. Many elderly people have lost their spouses, their friends and contemporaries resulting in a twofold loss of love: of persons to love and of persons who will return that love. A crying need exists for someone to assume a personal interest in these individuals. For a short while, this need was met, in part, by regular visits from the project team. In many cases, this individual attention and recognition meant as much, if not more than, the training services offered.

Hopefully service to the elderly blind population will be integrated into the already existing rehabilitation system which has long recognized the needs of the younger, employable blind.

COMMUNICATIONS

Procedures

Communications training offered in the Elderly Blind Project included handwriting, use of the telephone, training and assistance in obtaining talking and cassette books, reading and writing Braille, personal typing and tape recorder instruction.

Of the 408 referrals, 133 received project services. Training was not provided the remaining 275 for a variety of reasons. Persons were found ineligible because they did not meet the age requirements of 55 or older, were not legally blind, or did not live in one of the three counties covered by the project. Others refused services, and some had handicaps too severe to benefit from instruction. There

were others who could not be contacted after repeated attempts, and in some cases the referral had died.

Of the 133 referrals accepted, 124 were referred for evaluation by the communications teacher and 114 were actually provided instruction. All referrals were interviewed by the project coordinator initially. If a client was found eligible and indicated an interest in being seen by any or all of the project team of instructors, this information was relayed to us during our weekly staffing of cases.

The communications teacher in turn interviewed each client in his or her home and through this discussion the Communications Checklist of Instructional Needs Form was completed by assigning a numerical rating: level one - accomplishes task with little or no difficulty; level two - accomplishes task with some difficulty; level three - noticeably limited skill; level four - no skill. The level of skill was again given a numerical rating, using this same scale, at the end of each client's training program to indicate client's improvement. These results will be discussed later. A copy of the Checklist of Instructional Needs and Level of Attainment Form may be found in Appendix D.

Based on the interview with the client, needs were identified and a plan for training was determined. Each training program was tailored to the individual client. While the client was assisted in developing the program, the final decision concerning services received, was the client's. No training was given, even if it was obvious it would benefit the clients, unless they expressed a need and desire for training.

Once the training program was devised, the client was seen on a weekly basis ranging from one hour to three hours per visit. Occasionally training was interrupted due to illness or in the event of another obligation; but the main reason was due to snow and ice during the winter months making travel to homes difficult, if not impossible, to accomplish. On the average, clients were seen for a total of six hours over a period of three months.

Results

Skills taught in the communications area are discussed in order of the most often taught to the least often taught. It should be understood the total number evaluated for communications

services was 124 and the total number who actually received instruction was 114.

In the area of handwriting, 92 clients received some form of training. The majority received the basic handwriting guides and were trained to use them. Clients who only received the guides were those who had lost confidence in their ability and felt that due to their inability to see, they could not continue to write. Once they were oriented to the various guides and realized they would not have to give up writing, they resumed this skill with little difficulty.

Many people were only interested in being able to sign their name. Usually these individuals did not live alone and would depend on someone else to handle any necessary correspondence. Some persons required only a signature guide while three persons were taught to write their names who had never learned to do this earlier in life. Three clients learned to write the alphabet, numerals, and punctuation. These clients had been blind since birth or early childhood and had received their education through Romney School for the Blind, Romney, West Virginia, and were adjusted to their blindness. Except for handwriting, they exhibited very good communications skills. Other clients required a handwriting review as they had not used their handwriting since losing their sight and had forgotten how to form some of the letters of the alphabet.

Of those evaluated, 32 declined handwriting instruction. Fourteen of these simply refused, while another 14 had adequate skill and did not require instruction. The remaining four persons had problems with arthritis or were too senile, preventing instruction.

Of the 92 who received training in handwriting skills, 83 showed improvement by reaching a higher level of attainment. Reasons for the remaining nine showing no improvement included a lack of motivation, loss of interest and some accepting training just to be visited by the teacher for the social benefit, but making no real effort to learn.

A high value was placed on regaining the ability to use the telephone by clients. Of the total evaluated, 52 were provided instruction in this area. The instruction varied depending upon the degree of visual limitation. Some only needed a large numbered dial placed on their phone, while others required detailed

instruction on how to dial by touch. Many of these had been using the operator to place their calls. Of the 52 who received instruction in use of the telephone, 48 showed improvement. Low tolerance level and lack of mental ability were the reasons four showed no improvement.

Forty-two referrals were made to the West Virginia Library Commission, Services to the Blind and Physically Handicapped Section, for recorded discs and cassettes of books and magazines. Many of the clients were unaware of the talking books and cassettes which were available for use on the special record or cassette players by the Library Commission. Others already had one of these devices, but did not realize they could have both. Some, however, only chose the one machine which most suited their particular need. Overall, it was found that most clients preferred the records over the cassettes because the record players were easier to operate and more reliable than the easily fouled cassette tapes. Also, once a cassette tape became lodged in the machine, it was difficult for some blind persons to remove it and disentangle the sometimes complicated mess without assistance from another person. Problems arising with the records, however, were only minimal and could usually be rectified with ease by the blind person.

Braille instruction was not a popular skill with the project's elderly clients. With the average client's age being 72, it was difficult, if not impossible, to achieve much success with this skill even when the client was highly motivated. Braille requires a good tactile sense as well as the abilities to concentrate and memorize. These qualities are frequently severely limited in this age group.

Eighteen clients completed Braille alphabet training. Fourteen had no skill prior to instruction while four had received the pre-instructional rating of level two--accomplishes task with some difficulty. Of those completing alphabet instruction, 13 were able to use this skill as a written method of communication for themselves in tasks such as listing telephone numbers, making grocery lists, clothing identification, labeling food products, etc. Five, however, did not successfully complete the training for the reasons mentioned above.

Four clients completed Grade II Braille instruction. Grade II is a contracted form of Braille and most books and magazines are embossed in this way. One essential reason this segment of Braille was not taught more often, other than the fact that it is considerably

more difficult to learn, was that most elderly people preferred to utilize talking and cassette books and magazines as a means of regaining reading. They felt that it was so much easier to use this equipment rather than spend several months learning Braille to accomplish virtually the same end. Of the four receiving Grade II Braille instruction, three already had some prior Braille teaching. One had no previous training. After completion of instruction, all could read and write with little or no difficulty.

It is significant to note that all of these clients ranged in age from 57 to 64 at the time of instruction and had little difficulty with their touch. It was felt that if the project had received more referrals in the 55 to 65 age group, more clients would have completed this level of Braille training.

Typing instruction was attempted by only seven clients. This skill required a good memory, the ability to concentrate, and of utmost importance, excellent manual dexterity. Many clients in the elderly age group generally did not possess good abilities in these areas. Five clients significantly improved their skill in typing while two made no improvement. While typing would have been a very beneficial skill for most clients to learn, many declined training because at their age they had already developed, perhaps less efficient, but alternative means of communication.

Those clients who learned to use a tape recorder were quite successful, but only six expressed an interest and received instruction. One hundred refused training, three were not sufficiently mentally alert to benefit and 14 already had adequate skill in this area. From a practical standpoint, the tape recorder could have been a valuable communications tool to the elderly blind for such things as recording and playing back recipes, telephone numbers, grocery lists, and correspondence with others if the written means of communication was not within the realm of the client's skills. The tape recorders were also used for educational purposes and recording information from the talking books. While the benefits of being able to use the tape recorder were seemingly great, an obviously large number refused this service. As was indicated earlier, the teaching areas were individually tailored for each client to suit their particular needs and desires. Many clients, therefore, may have needed this service, but most did not desire it.

When the project began, use of the abacus was to be included in the communications curriculum. No client, however, expressed

an interest or a need for learning this method of calculation; therefore, training in this area was not taught.

Problems

Table 7 gives information for the communications skill areas with the number and percentage of clients taught. The number of clients column and percentages column will not total 114 and 100 percent respectively because most clients received a combination of the training skills. The number of clients evaluated in communications was 124. One hundred-fourteen received some type of training.

TABLE 7

DISTRIBUTION OF 114 CLIENTS TAUGHT COMMUNICATION SKILLS

Skill	Number of Clients	Percent
Handwriting	92	81
Telephone	52	46
Talking/Cassette Books	42	37
Braille-Alphabet	18	16
Braille-Grade II	4	4
Typing	7	6
Tape Recorder	6	5
Abacus	0	0

All services provided were based on the individual's expression of needs. It became increasingly obvious that many clients expressed a need for training, but did not follow through by completing the necessary homework to achieve their original goal. They continued to verbally express their need for a particular skill or an aid, but their actions soon indicated that perhaps there was no real need. These elderly clients were lonely and enjoyed the company

they received in having a teacher regularly visit their home.

Since delivery of services did occur in the home, this in itself, caused a problem in the teacher-client relationship. In a controlled environment such as a school for the blind or a rehabilitation center, the teacher sets the pace of the training schedule and the client has a responsibility to keep up with assignments. In working in a client's home, this situation was reversed and the client set the pace to a large degree. This happened because the teacher had to work around the normal functions of their everyday routines, such as friends dropping by, doctor's appointments, out-of-town visits, etc.

A large portion of clients refused training because they were accustomed to and dependent upon family or friends performing tasks for them and did not wish to change this arrangement by engaging in training which would allow them to do some of these functions for themselves.

Although it may seem reasonable that the elderly blind would have a definite need to learn Braille, typing, tape recorders and the abacus which logically should increase their ability to be productive and enjoy life, this need was apparently only seen by others and not the elderly blind, as the complexity of learning some of these skills was overshadowed by the limitations of old age. Being in a learning situation once again, but so late in life, made many clients feel inadequate and nervous. In addition, there were a variety of mental and physical limitations so common for the elderly which, in themselves, may have caused other restrictions to learning. Blindness in some cases was a minor obstacle to the teaching process in comparison to the limitations imposed by old age.

This concept is illustrated in the above-mentioned table which indicates the desire of the majority of clients to receive training in the more simple, but very practical and enjoyable skills of handwriting, telephone, and talking/cassette books.

Recommendations

Because talking/cassette books received such widespread enjoyment to those aware of them, it is disappointing to find a great number of visually impaired people who have never known the existence of this service. The lending libraries have an extremely valuable service to offer and should begin a program of education

and instruction in order to avail their program to all individuals in the blind community.

Blind adjustment training on an itinerant basis should be offered to the visually impaired of all ages, but not specifically to the elderly. They have some specific needs which should be met, i.e., provision of adaptive aids for continuing handwriting, regaining the use of the telephone, and provision of talking/cassette books so they can continue to read. The other skills were not found to be a major need of the elderly, but those who do desire such training could receive it if home instruction was available to all ages.

More could be accomplished by finding ways to include the elderly blind in activities outside their home and getting them involved with other people to alleviate the loneliness felt by most.

CHAPTER VI

EVALUATION

Specific criteria to be considered in evaluating the success of the program were listed in the program evaluation section of the original project proposal. In retrospect, some of the listed criteria were valid and others of little use.

The Number Of Clients Served And The Number Rehabilitated As A Result Of The Special Project

Actually the number served and the number rehabilitated was the same; cases closed received services - 103, cases closed received minor services - 30, total cases closed - received services - 133. The term "REHABILITATED" was questionable in that it could be defined as either improved functioning or, as it is used in vocational rehabilitation terms, employment. The project referred to rehabilitation as the client having reached his optimum level of functioning, be it in employment or in activities of daily living.

The Number Of Clients Found In The Survey In Relation To The Projected Estimates Of Number Of Clients To Be Served

It was estimated, for the three-year period of the project 300 older blind individuals would be served and 108 rehabilitated. Again, definition of terms was not clear. By served, the project definition was "those to whom services were provided." In the evaluation criteria listed in the project proposal, "served" indicated the total number of cases referred. Also, again, the project used the terms "served" and "rehabilitated" interchangeably as all those served were considered rehabilitated in the sense that their functioning was improved. In view of the above, the project served (clients referred to the project) 408, and rehabilitated (improved functioning) 133.

The Level Of Independence Attained By Each Client Receiving Services

- This item is discussed in Chapter V - Individual Reports.

The Attrition Number And The Number Not Feasible For Services

Two hundred seventy-five of the 408 clients referred did not receive services. Possibly one of the most disappointing aspects

of the project was the large number of people who refused services- 128 or 46 percent of the 275 who did not receive services and 31 percent of the total number referred. These were people who were probably eligible for, and would have benefited from, services. Table 8 shows the reason a referral did not receive services by referral source. Reasons for refusal of services are covered in Chapter V, Individual Reports.

Several items in Table 8 need further explanation. Table 8 shows eight referrals from nursing homes, six not receiving services, leading to the conclusion only two nursing home referrals were served. Actually, additional people were served in nursing homes having been referred by a different source, i.e. Department of Welfare and Housing Authority.

Also very disappointing were the very few referrals from physicians. Dr. Friedman (1971), notes "...the fact is that with few exceptions the ophthalmologist is conspicuous by his absence from most activities involving the rehabilitation system..." He feels this lack of communication between the ophthalmologist and rehabilitation can only be improved by training in medical school or residency. Letters were sent to all the ophthalmologists in the three-county area on two separate occasions explaining the program. Also, personal contacts were attempted. Only one ophthalmologist referred clients.

Those who did not receive services due to the severity of handicap had secondary disabilities, either physical or mental, that totally precluded even the slightest gain from any type of training program.

TABLE 8

DISTRIBUTION OF CASES NOT RECEIVING
SERVICES BY REFERRAL SOURCE AND REASON

	Number Of Referrals	Number Not Served	Handicap Too Severe	Refused	Not Over 55	Not Legally Blind	Not In 3 County Area	Death	No Contact	Percent Referrals Not Served
Nursing Home	8	7	3	3	0	0	1	0	0	75
Dept. Of Welfare	53	44	8	17	6	9	1	3	0	83
Division of Vocational Rehabilitation	53	31	0	15	3	7	0	1	5	58
Community Action	62	45	11	16	0	6	1	5	6	73
Housing Authority	43	28	3	12	0	9	1	3	1	65
Commission On Aging	8	4	2	1	0	1	0	0	0	50
Library Commission	67	57	2	38	0	7	2	5	3	85
Other Private Agency	4	3	0	1	0	1	1	0	0	75
Self	13	3	0	1	0	1	1	0	0	23
Physician	4	2	0	0	0	0	2	0	0	50
Individual	91	52	5	25	5	13	2	1	1	57

Achievements In Relation To Related Social Service Agencies, The Number Of Clients Needing And Provided Ancillary Services Directly Having Bearing On Their Rehabilitation And The Number And Nature Of In-Service Training Sessions Held With Related Agencies And Facilities

Community resources (Appendix F) were contacted with two aims in mind: Development of referral sources and education of community agencies and facilities regarding the older blind. Educational programs were presented to the Department of Welfare, Kanawha County Diabetic Fair, nursing homes, community action programs and Federation of the Blind programs. There was not a great deal of interest evidenced by clients in becoming involved in recreational activities outside their home. Those who were interested in community recreational activities seemed to have found an activity in which they could participate with little or no difficulty. This is not to say that all the clients were happily involved in leading rich, rewarding lives. By far the greater number did not have interests outside of their home. Their mental and physical resources precluded active participation in group activities. Also, many did not involve themselves in group recreational activities even when sighted, their recreation having been centered around their family and church. If these were no longer available to them, they lacked the skills and interest to attempt to face a new milieu and probably would not have done so even if their vision had not been impaired.

Clients were referred to community resources to meet their needs on an individual basis (Table 10). Those with vocational potential were referred to the Division of Vocational Rehabilitation. For the most part, the vocational goal was homemaker. Five clients in Kanawha County were interested in furthering their education through the community schools adult education program and one client was referred to the Hadley School for correspondence courses. One client was referred to the West Virginia Rehabilitation Center to participate in the Kurzweil Reading Machine Program and 17 were referred to the Optical Aids Clinic at the West Virginia Rehabilitation Center. It should be noted that, by referral, the project staff actively arranged services with the community resource. For example, the forty-two referrals to the library commission included making all the arrangements for a client to receive talking books. A referral was not a simple giving of a name and phone number to the community resource or to the client.

The Goodwill Industries Homebound Program, developed during the final year of the project, appeared to be one that will be of great service to the population served by the project. The areas of service Goodwill Industries will offer include the following:

transportation, ability development activities, vocational training, assistance in income supplementation through marketing of skill or hobby developed during training, and in-home exercise to aid in mobility and coordination. Unfortunately, the project is ending before the results of this program can be assessed.

Community Resources were used to a greater extent in Kanawha County, possibly because the office was located in Kanawha County and the project staff had all previously worked in Kanawha County and were more familiar with the resources available in the County. All community resources contacted were eager to cooperate and interested in providing services to the population served by the project. In fact, many were already doing so with no hesitancy because of the visual problems.

A Determination Of The Number Of Clients Served Who Have Definite Vocational Potential

For the most part, all clients considered to have vocational potential were, at some point, referred to the State Agency field program. Table 11 shows the number referred and the Division of Vocational Rehabilitation status at the time of referral. The one case referred in Status 28 (closed after program initiated) completed the training program, but died shortly thereafter. Those cases in Status 22 (in employment) were transferred to the field program for provision of any additional services that might be needed for the client's complete vocational adjustment. The cases transferred in Status 18 (rehabilitation training) were continuing to receive training services, but needed assistance, particularly in the area of medical attention that could be better provided through the field program. The one case transferred in Status 12 (completion of individualized written rehabilitation program) was originally diagnosed as legally blind, but further examination showed glasses improved his vision to better than 20/200. It was felt the original misdiagnosis was due to the client's severe hearing problem interfering with his communication skills. The field program was able to provide both hearing aid and glasses. The cases transferred in Status 02 (applicant) were those with vocational potential who were not legally blind, but had visual problems interfering with their optimum level of performance, or those who were legally blind, but whose vision would be improved with treatment. The clients referred in Status 00 (referral) were referrals either under age 55 or not in the three-county area served by the project.

There were additional clients with vocational potential who were not referred to the field program because they refused to sign the application form. Project services were not denied, as this was not a basic requirement to receive project services. As has been mentioned previously, the vocational goal in most cases was that of a homemaker with services being provided to five clients who were vending stand operators and clients functioning in competitive employment, i.e. sales clerk in a department store, grocery store owner/operator, author, piano tuner and groundsman supervisor.

TABLE 9
DISTRIBUTION OF REFERRALS
BY SOURCE

Referral Sources	Percent
Nursing Home	2
Hospital	1.5
Department of Welfare	13
Division of Vocational Rehabilitation	13
Other Public Agencies	
Community Action	15
Housing Authority	11
Commission on Aging	2
Library Commission	16
Diabetic Association	1.5
Other Private Agencies	1
Self	3
Physician	1
Individual	22

TABLE 10
DISTRIBUTION OF CLIENTS REFERRED
TO COMMUNITY RESOURCES

Resource	Number Of Clients
Division of Vocational Rehabilitation	62
Optical Aids Clinic	17
Goodwill Industries	6
Homebound Program	5
Community Schools	7
Department of Welfare	3
Community Action	2
Legal Services	1
Fire Department	2
Hospital	2
Dial-A-Ride	2
Senior Citizens Groups	2
Kurzweil Program	1
Dental Clinic	1
Family Service	1
Veteran's Administration	1
Lions Club	1
Operation Good Morning	1
Library Commission	42
Hadley School	1

TABLE 11

CASES REFERRED TO THE FIELD PROGRAM

Status At Time Of Referral	Total
28	1
22	37
18	2
12	1
02	11
00	10

A Study Of The Housing Or Geographic Situations Of The Older Blind
Within Each Of The Target Counties

TABLE 12

GEOGRAPHIC DISTRIBUTION OF STATE
 CABELL, WOOD, KANAWHA COUNTIES
 (1970), AND PROJECT POPULATION

Area	Rural Population (Percent)
West Virginia	61
Cabell County	33
Kanawha County	32
Wood County	33
Project Population (N=374)	12

A very small percentage of the project population lived in rural areas. West Virginia has a very large rural population, but the counties covered by the project were the three most populous counties in the state; and, as Table 12 indicates, have small rural populations. Urban was defined as within the city limits, rural accessible as outside the city limits but accessible by bus, taxi or car, and rural inaccessible locations were those that could be reached by car or taxi only when the weather was good and the road (dirt) passable.

The project staff discussed further in-depth study of housing conditions, but due to the difficulty of making value judgments, did not further pursue this area. There were clients living in homes the staff might have felt were substandard according to their values, but to the client, it was home. In many cases they had lived there their entire lives and they were very content and proud of their homes. Also, the areas covered did not include cities large enough to have the type of slum conditions found in very large metropolitan areas.

A Measure Of Consumer Satisfaction And A Reaction By Both Consumer And Professional As To The Effectiveness Of And Need For Itinerant Rehabilitation Services For The Client In The Home

It was the original intent of both the project proposal and the project staff that a consumer evaluation be made after completion of services for each client. An instrument was devised for this purpose and may be found in Appendix C of this report. The evaluation was a survey form and consisted of questions designed to determine how the clients themselves viewed their accomplishments in homemaking, communications, and mobility. The form also solicited client comments on the project in general.

After many evaluations were completed, the value of the results became questionable. It was evident that most clients were pleased with project services, but it was also evident that a number were responding to please the surveyor. In addition, the results of the survey were almost 100 percent predictable in each case as the client responded positively to all areas in which he was taught and made progress. Furthermore, the survey questions had to be interpreted in many cases to fit the individual's own instruction. The interpretations may have varied depending upon whether the surveyor was the homemaker, communications or mobility specialist.

Because of this halo effect, the staff felt that the statistical information and comments reported in the results sections of this

report reflect both the instructor's and client's attitudes toward service. It is recommended that should consumer evaluations be completed in the future, to evaluate various projects' effectiveness, they be completed by a third party and that the format be tested thoroughly in advance.

Representative comments by the clients at the conclusion of the questionnaire were as follows:

1. "Services are very excellent. Opportunity through Rehab is more than excellent. Goes to prove what can be accomplished when an organization such as Rehab is as interested in the blind and handicapped as they are."
2. "Anyone who doesn't take advantage of this would be a loser. It has been a help to me."
3. "It was helpful to know that someone was interested to come and see me and to ask what my needs are."
4. "Medical exams meant most to me. Self confidence and morale are greater now."
5. "It's just a marvelous project. I appreciate all you've done for me so much."
6. "Alarm clock is wonderful, highly recommend this service."
7. "Would like to see age lowered--more recreational areas, crafts."
8. "It was a colossal help to me. It's really a great program."
9. "Enjoyed your visits and the devices provided."
10. "West Virginia money is not wasted here."
11. "Liked seeing project staff."
12. "These services were a blessing."
13. "Wonderful, cooperative, understanding people."
14. "Really has been a help."
15. "Good instructors."

The professional reaction measure was in the form of a postcard mailed with a cover letter (Appendix C). It was mailed to 21 professionals who had referred clients and 13 returned the postcard. Once again, the results were positive as is shown in Table 13.

TABLE 13
RESULTS OF PROFESSIONAL REACTION FORM

Item	Percent
<u>Services Helped</u>	
Yes	85
Somewhat	8
No	7
<u>Services Needed</u>	
Yes	100
Somewhat	0
No	0

CHAPTER VII

RECOMMENDATIONS

1. The Division of Vocational Rehabilitation should provide blind adjustment training services on an itinerant basis to all eligible citizens of West Virginia.
2. There were a few people who would have benefited from services who were not legally blind, but might have been termed functionally blind. Possibly, eligibility would be better determined by using a functional definition of blindness.
3. If, in the future, the concept of Vocational Rehabilitation is broadened to include provision of services to all who are disabled to allow them to improve quality of life as well as to improve vocational functioning, the project has shown this can be done within the current framework of the Agency.
4. The elderly blind need recreation and socialization. The answer to date has been to provide this within the framework of daycare centers, senior citizens centers and other type settings. For some, this does fulfill a need. The project observed many who had no interest in this type of activity, but they attempted to learn, and did learn skills and accomplished objectives important to them. As a by product, recreation and socialization needs were fulfilled. There is no doubt, the elderly need some type of continuing contact with the world outside of their home. If they will not or cannot go to it, it must come to them whether it be in the form of a friendly visitor, or better still, a program such as a vocational rehabilitation itinerant teaching program--a program that shows the elderly blind they can continue to do much they thought was no longer possible.
5. The system of provision of services proved to be one that worked very smoothly. Paperwork performed by the project teaching staff was kept to an absolute minimum of short narrative reports of each teaching session and completion of evaluation forms at the beginning and ending of training. The counselor/coordinator saw the client initially, arranged all examinations and completed all agency forms. The intent in the project proposal was that the counselor/coordinator would also provide counseling; and in some instances this was accomplished; but the rapport developed by

the teachers with the clients was such that counseling became an integral part of their teaching. This may have been because the mobility specialist, homemaker teacher and communications teacher were also trained counselors as well as trained to teach their respective fields. With the growing bureaucratic complexities, the Division of Vocational Rehabilitation might look into the possibility of the division of counselor responsibilities.

6. The age group which the project served, average age 72, should not be overlooked by the field program. If an itinerant teaching program is not available, some of the simpler needs of the blind homemakers could be partially met through provision of adaptive aids if rehabilitation counselors and other professionals serving this population were aware of the existence of these devices and methods of training clients to use them.
7. It is the consensus of the project staff that the Division of Vocational Rehabilitation is presently the only Agency that has expertise to provide the services that will adequately meet the needs of the disabled elderly blind who wish to continue to be independent members of their community.

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APPENDIX A
STATISTICAL DATA

SUMMARY OF STATISTICAL DATA ON 133 CLIENTS RECEIVING SERVICES

	Number	Percent		Number	Percent
<u>Sex</u>			<u>Work History</u>		
Male	44	33	Homemaker	26	20
Female	89	67	Unskilled	17	13
			Semiskilled	31	23
<u>Race</u>			Skilled	25	18
White	118	89	Professional	24	18
Negro	15	11	Vending Stand	8	6
Indian	0	0	None	2	2
Other	0	0			
<u>Marital Status</u>			<u>Current Employment</u>		
Married	50	37	Homemaker	80	60
Widowed	56	42	Unskilled	0	0
Divorced	9	7	Semiskilled	1	1
Separated	2	2	Skilled	2	1.5
Never Married	16	12	Professional	2	1.5
			Vending Stand	5	4
<u>Education</u>			None	43	32
1st - 6th Grade	37	28	<u>Previous DVR Experience</u>		
7th - 11th Grade	38	29	Yes	49	37
High School Diploma	27	12	No	84	63
College	19	14			
College Degree	12	9	<u>Consumer Involvement</u>		
None	0	0	Yes	24	18
			No	109	82
<u>Location</u>			<u>Telephone</u>		
Urban	113	85	Yes	130	98
Rural Accessible	18	14	No	3	2
Rural Inaccessible	2	1			
<u>Living Arrangement</u>			<u>Transferred to DVR</u>	52	39
Alone	60	45	<u>Extent of Blindness</u>		
With Spouse	51	38	Total	38	32
With Family Member	13	10	Partial	82	68
With Non-Family Member	3	2			
Controlled Environment	6	5	<u>Onset Age</u>		
<u>Financial Support</u>			0-1	10	8
SSDI	11	8	2-25	14	11
SS	60	45	26-40	11	8
SSI	16	12	41-50	4	3
SS & SSI	13	10	51-60	23	17
Family & Friends	12	9	Over 60	71	53
Other	21	16	Not Available	1	—

Average cost per case of clients receiving services (medical examinations, special aids and appliances)...\$95.20

Average Age - 72

SUMMARY OF STATISTICAL DATA ON 133 CLIENTS
RECEIVING SERVICES (continued)

Cause of Visual Problems

	<u>Total</u> <u>Blindness</u>	<u>Partial</u> <u>Blindness</u>	<u>Total</u>	<u>Percent</u>
Cataract	<u>1</u>	<u>15</u>	<u>16</u>	<u>12</u>
Glaucoma	<u>6</u>	<u>13</u>	<u>19</u>	<u>14</u>
Diabetic Retinopathy	<u>7</u>	<u>11</u>	<u>18</u>	<u>13</u>
Macular Degeneration	<u>0</u>	<u>35</u>	<u>35</u>	<u>26</u>
Retinitis Pigmentosa	<u>1</u>	<u>4</u>	<u>5</u>	<u>4</u>
Corneal Disease & Degenerative Conditions	<u>1</u>	<u>1</u>	<u>2</u>	<u>1</u>
Detached Retina	<u>1</u>	<u>5</u>	<u>6</u>	<u>5</u>
Other Infectious Degenerative Diseases	<u>3</u>	<u>4</u>	<u>7</u>	<u>5</u>
Congenital Malformation	<u>1</u>	<u>4</u>	<u>5</u>	<u>4</u>
Accident, Poisoning, Exposure, Injury	<u>10</u>	<u>4</u>	<u>14</u>	<u>11</u>
Ill-Defined & Unspecified Causes	<u>1</u>	<u>5</u>	<u>6</u>	<u>5</u>

Secondary Disability

	<u>Total</u>	<u>Percent</u>
Cardiac Conditions	<u>22</u>	<u>16</u>
Diabetes	<u>19</u>	<u>14</u>
Hearing Loss	<u>17</u>	<u>13</u>
Arthritis	<u>9</u>	<u>7</u>
Psychoneurotic	<u>6</u>	<u>4</u>
Respiratory	<u>6</u>	<u>4</u>
Stroke	<u>4</u>	<u>3</u>
Malignant Neoplasms	<u>3</u>	<u>2</u>
Urinary System	<u>3</u>	<u>2</u>
Polio	<u>2</u>	<u>2</u>
Disorders of Nervous System	<u>2</u>	<u>2</u>
Amputation	<u>1</u>	<u>1</u>
Mental Retardation	<u>1</u>	<u>1</u>
Colostomy	<u>1</u>	<u>1</u>
Varicose Veins	<u>1</u>	<u>1</u>
Speech	<u>1</u>	<u>1</u>
None	<u>32</u>	<u>24</u>
Not Available	<u>3</u>	<u>2</u>

SUMMARY OF STATISTICAL DATA ON 275 CLIENTS
CLOSED FROM REFERRAL

<u>Sex</u>	<u>Number</u>	<u>Percent</u>
Male	<u>97</u>	<u>35</u>
Female	<u>178</u>	<u>65</u>
<u>Location of Home</u>		
Urban	<u>217</u>	<u>79</u>
Rural Accessible	<u>23</u>	<u>8</u>
Rural Inaccessible	<u>1</u>	<u>1</u>
Not Available	<u>34</u>	<u>12</u>
<u>Telephone</u>		
Yes	<u>205</u>	<u>75</u>
No	<u>23</u>	<u>8</u>
Not Available	<u>47</u>	<u>17</u>
<u>Reason for Closure From Referral</u>		
Handicap too severe	<u>34</u>	<u>12</u>
Refused Services	<u>128</u>	<u>46</u>
Not Eligible	<u>80</u>	<u>29</u>
Not age 55	<u>14</u>	<u>5</u>
Not Blind	<u>55</u>	<u>20</u>
Not in Three County Area	<u>11</u>	<u>4</u>
Unable to Locate	<u>15</u>	<u>6</u>
Death	<u>18</u>	<u>7</u>
Average Age - 71		

DISTRIBUTION OF REFERRALS BY SOURCE

Referral Sources

	<u>Cabell</u>	<u>Kanawha</u>	<u>Wood</u>	<u>Total</u>	<u>Percent</u>
Nursing Home	<u>2</u>	<u>6</u>		<u>8</u>	<u>2</u>
Hospital	<u>1</u>		<u>1</u>	<u>2</u>	<u>.5</u>
Department of Welfare	<u>23</u>	<u>14</u>	<u>16</u>	<u>53</u>	<u>13</u>
Division of Vocational Rehabilitation	<u>18</u>	<u>18</u>	<u>17</u>	<u>53</u>	<u>13</u>
Other Public Agencies					
Community Action	<u>9</u>		<u>53</u>	<u>52</u>	<u>15</u>
Housing Authority	<u>1</u>	<u>42</u>		<u>43</u>	<u>11</u>
Commission on Aging	<u>4</u>	<u>4</u>		<u>8</u>	<u>2</u>
Library Commission	<u>21</u>	<u>31</u>	<u>15</u>	<u>67</u>	<u>16</u>
Diabetic Association		<u>1</u>		<u>1</u>	<u>.5</u>
Other Private Agencies		<u>1</u>	<u>2</u>	<u>3</u>	<u>1</u>
Self	<u>2</u>	<u>9</u>	<u>2</u>	<u>13</u>	<u>3</u>
Physician		<u>2</u>	<u>2</u>	<u>4</u>	<u>1</u>
Individual	<u>20</u>	<u>39</u>	<u>32</u>	<u>91</u>	<u>22</u>
TOTAL	<u>101</u>	<u>167</u>	<u>140</u>		
TOTAL 3 COUNTY				<u>408</u>	

APPENDIX B
PUBLIC INFORMATION

COMPREHENSIVE SERVICES TO THE DISABLED ELDERLY BLIND

Federal Project Number 30-P-65027/3-01
Rehabilitation Services Administration
Department of Health, Education and Welfare

State Board of Vocational Education
Division of Vocational Rehabilitation
Charleston, West Virginia
Thorold S. Funk, Director

"Is the older person who has spent his life working, raising a family and making his contribution to the general well-being of our country and society, any less worthy of receiving the very best than the young child just setting out on life's journey?"

We believe the answer to this question is to provide services to the older blind through a comprehensive rehabilitation team who will work on an itinerant basis going into the community and providing services in the home and neighborhood where the individual lives rather than displacement from the known and secure environment to receive services. Approximately one-half of West Virginia's 4000 blind population is over the age of 55, yet only five per cent of these individuals are currently being served in any fashion through the regular Agency field program.

Comprehensive services (personal adjustment, recreation, communication, homemaking skills and mobility skills) have not been provided simultaneously to the elderly blind. This project seeks to address itself to this apparent need. To be able to function more adequately, securely and independently with confidence is the goal of the project for those elderly individuals with the disability of blindness.

WHO IS ELIGIBLE?

Any individual age 55 and above residing in the counties of Kanawha, Cabell and Wood who has the disability of legal blindness verified by a physician's statement is eligible for the Elderly Blind Project. The cause of a person's loss of sight has no bearing upon his eligibility. It makes no difference whether it is the result of an injury, a disease or a natural deformity. Nor does the fact that the individual may have previously collected damages, insurance or disability insurance affect his eligibility.

If a person has any question about his eligibility, his doubts probably can be cleared up during his first interview with the project counselor.

SERVICES OFFERED

1. *Counseling and Guidance.* This is provided in order to determine the client's particular needs and to program the most effective services from the Project to help meet those needs. Fear of the unknown, breaking old habits, and accepting more efficient methods in which to make daily life more pleasant and independent will be addressed as problem areas the elderly blind face. Helping the client to become less frightened, less bitter and more accepting and tolerant of his own environment will be pursued as well as ease of implementation of services if found feasible and desirous.

2. *Orientation and Mobility Training.* Aid to helping an individual discover the pleasures of and knowing his environment is a priority. The frustration of not knowing one's surroundings as well as the nearby community can and does lead to isolation and a limited routine. Orientation and mobility training can do much to alleviate needless isolation within the blind person's own home and life beyond his walls.
3. *Activities of Daily Living (ADL) and Homemaking.* The maintenance of good personal care—cleanliness, good grooming, appropriate selection of clothing, etc.—is not only important in and of itself, but is vital to the support of morale and self-respect in the blind person just as it is in the sighted. The ability to eat neatly and in a relaxed manner both at home and in public is another important contribution to the individual's sense of well-being and dignity. Instruction in these areas of daily living in addition to instruction in nutrition and safe and efficient cooking, cleaning and laundry methods will be provided by the Project homemaker teacher.
4. *Communication Training.* Effective communication tailored to the needs of the blind individual can do much to help provide self-esteem and confidence. Braille, typing, audio devices, handwriting, etc., will be explored in order to determine the best effective method of communication for the client's use—not only in the labeling of home items, but in communication with others.
5. *Recreation Skill-Building.* Many people prefer to spend time alone; some do not, and the elderly blind may be unable to travel far from their homes due either to blindness or physical handicaps. Those who cannot do so have an eternity of time on their hands. Providing them with skills to make their idle time meaningful and pleasurable also builds confidence as well as a reason for living and enjoyment of life. Opportunities to be introduced to community activity resources will be provided so that sharing with others in a social atmosphere will keep the elderly blind in touch with the lives of others. To those who are confined, the community activity resources will be notified of their existence and need so that the recreation can come to them where possible.
6. *Possible referral to other social service agencies.* The Project provides for a general medical examination and a visual examination. If services not covered by this Project are found to be needed, Project staff will make referral to the appropriate social service agency for possible provision of services.

Loneliness, loss of self-esteem, loss of friends and relatives, isolation in a room or hollow, fright, bitterness, pain and pride equal walls of defense and self-protection. These are also barriers of enormous difficulty to surmount.

Do you know of a blind person age 55 or older who could be provided one or more of the Project's itinerant services? If so, please give us a call. We will be delighted to talk with you and explain our services in detail. We are also available to talk to service groups, church organizations and individuals who desire to know more about this Project and how to work with blind individuals.

HOW IS APPLICATION MADE?

Any individual or agency may contact Project staff by writing or calling the following addresses or phone numbers:

Services to the Elderly Blind
1033 Quarrier Street
Suite 700
Charleston, West Virginia 25301
Phone: (304) 348-5988 or 348-5989

Division of Vocational Rehabilitation
Suite 301 Morris Square
1212 Lewis Street
Charleston, West Virginia 25301
Phone: (304) 348-3408

Division of Vocational Rehabilitation
200 Keith-Albee Building
929½ Fourth Avenue
Huntington, West Virginia 25701
Phone: (304) 529-2711

Division of Vocational Rehabilitation
Post Office Box 1805
Parkersburg, West Virginia 26101
Phone: (304) 485-6349



STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

Comprehensive Services to the Elderly Blind

THOROLD S. FUNK
DIRECTOR

1033 Quarrier Street, Suite 700

Charleston, West Virginia 25301

(304) 348-6988
(304) 348-6989

June 17, 1977

WXIL-Regional Radio
240 Grand Central Mall
Parkersburg, West Virginia 26101

Dear Sir:

We would appreciate your broadcasting this 30-second spot
wherever you have available space and as frequently as possible.

Thank you.

Sincerely,

Joan Skees
Counselor/Coordinator

VOCATIONAL REHABILITATION PROJECT FOR THE BLIND PROVIDES FREE TRAINING SERVICES TO THOSE LEGALLY BLIND, AGE 55 AND OVER. YOU MAY BE ELIGIBLE TO RECEIVE SPECIAL AIDS AND TRAINING IN YOUR HOME. SERVICES INCLUDE TRAINING IN MOBILITY, HOUSEHOLD ACTIVITIES AND BRAILLE. SPECIAL AIDS SUCH AS WRITING GUIDES, LABELING DEVICES, TIMERS AND OTHER AIDS ARE AVAILABLE. FOR FURTHER INFORMATION CALL 348-5988. THAT'S VOCATIONAL REHABILITATION, PROJECT FOR THE ELDERLY BLIND 348-5988.



STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

THOROLD S. FUNK
DIRECTOR

Comprehensive Services to the Elderly Blind
1033 Quarrier Street, Suite 700
Charleston, West Virginia 25301

(304) 348-6982
(304) 348-6989

May 25, 1977

Dear Dr.

The brochure I have enclosed will give you information regarding Vocational Rehabilitation's Project "Comprehensive Services to the Elderly Blind." We are providing training services, in the home, to those who are legally blind, over age 55, residing in Cabell, Wood and Kanawha Counties.

We would welcome an opportunity to discuss our project with any of your patients you feel would benefit from our services.

Either call or have your patients call Vocational Rehabilitation in Huntington, 529-2711 and ask to be contacted by the Project for the Elderly Blind, or write to Vocational Rehabilitation, Project for the Elderly Blind, 1033 Quarrier Street, Charleston, West Virginia 25301.

Sincerely,

Joan Skees
Counselor/Coordinator



STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

Comprehensive Services to the Elderly Blind

1033 Quarrier Street, Suite 700

Charleston, West Virginia 25301

THEODORE S. FUNK
DIRECTOR

(304) 348-5988
(304) 348-5989

September 13, 1976

Dear

Your name was referred to our office by the Department of Welfare as one who might be interested in our Project for the Elderly Blind. The Project serves any individual aged 55 and above residing in the Counties of Kanawha, Cabell and Wood who has the disability of legal blindness. The services provided include counseling and guidance, orientation and mobility training, activities of daily living and homemaking services, communication training (including Braille, typing, handwriting, talking books, etc.), recreation skill building and possible referral to other social service agencies. These services are provided by a team going into the home and neighborhood where the individual lives.

I would appreciate your indicating at the bottom of this letter if you wish to receive services. If so, I also would appreciate your filling in your current address and your phone number. I am enclosing a self-addressed stamped envelope for your convenience in replying.

If you have any questions, please contact me at 348-5988 in Charleston or contact Mr. George McGhee with Vocational Rehabilitation in Parkersburg, phone number 485-6349.

Sincerely,

Joan Skees
Counselor/Coordinator

I am interested in Project Services _____
My present address is _____
My phone number is _____

I am NOT interested in Project Services _____



STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

THEODORE S. FUNK
DIRECTOR

Comprehensive Services to the Elderly Blind
1033 Quarrier Street, Suite 700
Charleston, West Virginia 25301

(304) 348-6988
(304) 348-6989

July 27, 1977

Dear

Your name has been referred to our office as one who might be interested in services provided by our new project for the blind. You may be eligible to receive special aids and training in your home.

If you would like further information, please fill out the bottom of this letter and return it in the enclosed envelope.

Sincerely,

Joan Skees
Counselor/Coordinator

I would like further information _____

My telephone number is _____

I am not interested in services _____



**STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION**

Comprehensive Services to the Elderly Blind

1033 Quarrier Street, Suite 700

Charleston, West Virginia 25301

(304) 348-5988
(304) 348-5989

**THOROLD S. FUNK
DIRECTOR**

May 11, 1977

Dear

The attached referrals have been contacted and received services as indicated.

Thank you for these referrals and please feel free to contact our office in Charleston, 348-5988, if you find others you feel might need training services.

Sincerely,

Joan Skees
Counselor/Coordinator

APPENDIX C
EVALUATION FORMS

Comprehensive Services to the Disabled Elderly Blind

Federal Project #30-P-65027/3-01

The project for the elderly blind is a service and research project funded for three years. Whether or not these services will continue to be provided and how they will be provided will depend on information received during the three year period. For this reason, we feel that it is very important that we receive your comments regarding the services you have received.

HOMEMAKING AND ADL

	<u>Yes</u>	<u>Somewhat</u>	<u>No</u>	<u>N/A</u>
1. As a result of Project services, do you feel any better able to take care of your own homemaking or self-care needs?	1. ☐	☐	☐	☐
2. Do you do more activities in these areas than you did before?	2. ☐	☐	☐	☐
3. Are familiar homemaking or self-care tasks any easier to perform now.	3. ☐	☐	☐	☐
4. Do you feel any safer or more self-confident when you do dangerous tasks such as using the stove?	4. ☐	☐	☐	☐
5. Do you rely on family and friends any less to help you with your homemaking activities?	5. ☐	☐	☐	☐
6. Some people who are blind are surprised at some of the things they have been able to do. Do you do anything in the homemaking or self-care areas that you felt were impossible to do before?	6. ☐	☐	☐	☐

COMMUNICATION

7. Has learning what you have in braille been useful to you?	7. ☐	☐	☐	☐
8. Do you use the typing skills you learned or improved to communicate better with others?	8. ☐	☐	☐	☐
9. Has the handwriting you have learned made you any less dependent on others?	9. ☐	☐	☐	☐
10. Have the guides provided by the project made handwriting easier.	10. ☐	☐	☐	☐
11. Is it easier (or now possible) for you to use talking book services because of the project?	11. ☐	☐	☐	☐
12. Because of what you learned of braille, typing, handwriting, and tape recorders, do you require any less assistance from your family or friends?	12. ☐	☐	☐	☐
13. Has learning to use a tape recorder for lists, letters, recipes, etc., been valuable to you?	13. ☐	☐	☐	☐

MOBILITY

- | | <u>Yes</u> | <u>Somewhat</u> | <u>No</u> | <u>N/A</u> |
|---|------------------------------|--------------------------|--------------------------|--------------------------|
| 14. Do you use any new techniques in mobility that help you move about with greater safety? | 14. ☐ | ☐ | ☐ | ☐ |
| 15. Do you feel more confident when you travel either by yourself or with others? | 15. ☐ | ☐ | ☐ | ☐ |
| 16. Are you any less dependent on your family or friends' assistance when you want to go somewhere? | 16. ☐ | ☐ | ☐ | ☐ |
| 17. Have the mobility skills you learned helped you to go places that you would not go before? | 17. ☐ | ☐ | ☐ | ☐ |

GENERAL

- | | | | | |
|--|------------------------------|--------------------------|--------------------------|--------------------------|
| 18. Do you participate more in community activities now as a result of project services? | 18. ☐ | ☐ | ☐ | ☐ |
| 19. In general, do you feel project services have helped you to meet your needs with less help from others? | 19. ☐ | ☐ | ☐ | ☐ |
| 20. After your first contact with the project coordinator, did you understand what services the project would offer? | 20. ☐ | ☐ | ☐ | ☐ |
| 21. If the answer to #21 is "No" or "Somewhat", please indicate what was not fully explained. | | | | |

22. How did you first hear about the project?

Phone: _____
 Letter: _____
 Friend: _____
 other: _____

23. Comments (Please include any information you feel would be helpful or would improve services):

Interviewed by: _____



STATE BOARD OF VOCATIONAL EDUCATION
DIVISION OF VOCATIONAL REHABILITATION

THOROLD S. FUNK
DIRECTOR

Comprehensive Services to the Elderly Blind
1033 Quarrier Street, Suite 700
Charleston, West Virginia 25301

December 8, 1977

(304) 348-6988
(304) 348-6989

The Project for the Elderly Blind is a Service and Research Project funded for three years to provide homemaker, communications and mobility training, in the home, to those legally blind and over age 55 in Kanawha, Cabell and Wood Counties. Whether or not these services will continue to be provided and how they will be provided will depend on information received during the three year period. For this reason, we feel it is very important we receive your comments regarding services we have provided.

A self-addressed, stamped postcard is included for your convenience.

POSTCARD

1. Do you feel Project services have helped your referrals meet their needs with less help from others?

Yes Somewhat No

☐ ☐ ☐

2. Do you feel this type of service is needed for the older blind in your community?

Yes Somewhat No

☐ ☐ ☐

3. Comments: Please include any information you feel would be helpful or would improve services.

APPENDIX D
PROJECT FROMS

Last Name First Middle

Address

Social Security Number: _____

County: _____

Referral Date: _____

Phone: _____

Referral Source: _____

Age: _____

Sex: _____

Race: _____

Marital Status: _____

Education: _____

Location of Home: _____

Living Arrangement: _____

Financial Support: _____

Work History: _____

Current Employment: _____

Previous Rehab. Service: _____

Consumer Involvement: _____

In-Service Date: _____

Onset Age: _____

Cause of Blindness: _____

Secondary Disability: _____

Referred To: _____

Services Provided: _____

Closure Reason: _____

Closure Date: _____

FISCAL

NAME _____

EXAMS/ABSTRACTS

General Medical - \$18.50

Visual/Ophthalmological

Hearing

Duplication of Medical Records \$6.00

Abstracts \$9.00 ea. - GM _____ Visual/Ophth. _____ Hearing _____

MOBILITY

CANES - 54" \$9.95 60" \$10.20

Nylon Tips - 75¢ ea. x 2

Blindfolds - \$1.85 ea.

OTHER

HOMEMAKING - ADL

Braille Timer - \$6.95

Braille Watch - \$26.95

Needle Threader - 70¢

Dymo Tape - (6rolls 3/\$3.75) (approx.)

Miniature Fruits & Vegetables & Alphabets (approx.) (Master \$3.50)
\$2.00 (Maxi \$2.25)

Single Line Slates \$3.75

Plastic Strips (approx.) 85¢ pkg.

Alarm Clock - \$11.25

Oven Mits - \$2.10

Cassettes - \$1.19 ea.

Clothing Tags - FREE

OTHER

COMMUNICATIONS

Braille Teaching Manual - \$3.40

Letter-Writing Guide & Envelope 30¢ set

Telephone Dial Guides - reg. 28¢ Large Print 50¢

Handwriting paper - dark line (500 shts. in rm.) \$6.25 pkg. (approx.)

Handwriting paper - raised line (500 shts. in rm.) \$4.60 pkg. (approx.)

Large Dot Braille Slates - \$15.00

Regular Dot Braille Slates & Stylus - \$8.00

Marks Writing Guide - \$11.95 - Script Guide \$11.95

Signature Guides - 95¢

Broad Tip Magic Marker - 45¢

Single Line Slate - \$3.75

Braille Erasers - 12¢ ea.

Large or Small Handled Stylus - 15¢ ea.

Cassettes - \$1.19

OTHER

COUNSELING AND GUIDANCE

RECREATION

TOTAL

WEST VIRGINIA REHABILITATION CENTER
OPTICAL AIDS CLINIC

Counselor's Interview Form

OAC NO: _____

CLINET'S NAME: _____ DATE _____

STREET: _____ CITY: _____ STATE: _____

AGE: _____ RACE: _____ MARITAL STATUS: _____

PHONE: _____ REFERRED BY: _____ REPORT: _____

CASE HISTORY - GENERAL

Educational Years Completed 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17+

Special Courses, Degrees held, etc. _____

Vocational Summary of Work History _____

Interests, Hobbies, etc. _____

CASE HISTORY - Present Visual Status

BEST VISION: O. D. _____ O.S. _____ O.U. _____

DETERIORATION: Past few mos. _____ Past year _____ Past few yrs. _____

TRAVEL VISION: Outdoors alone _____ Known location _____ strange locat. _____
cross streets alone _____ without cane _____ day _____
night _____

LIGHT TOLER: To sunlight _____ dull day _____ night vision _____
outdoors _____ shade eyes _____ wears sunglasses _____

DIS. VISION: See street signs _____ house numbers _____ recognizes proper
bus _____ watches movies _____ TV _____

NEAR VISION: Read headlines _____ sub headlines _____ newsprint _____
books _____ magazines _____ typewritten material _____
handwriting _____ Braille _____

COLOR VISION: Blue _____ Red _____ Green _____

SPECIAL VISUAL PROBLEMS: _____

QUARTERLY PROGRESS REPORT ON PROJECT OR SPECIAL PROGRAM

Quarter Ending: _____

91

Page Two

Total

(26)

year (26)

TOTAL CASES

Total

(26)

year (26)

TOTAL CASES

Code

TOTAL

TOTAL 3 COUNTY

COMMUNICATIONS CHECKLIST OF INSTRUCTIONAL NEEDS AND LEVEL OF ATTAINMENT

Client's Name _____ Date Program Started _____

Total Hours Instruction _____ Date Program Completed _____

Rating Scale

- 1 Accomplishes tasks with little or no difficulty
- 2 Accomplishes tasks with some difficulty
- 3 Noticeably limited skill
- 4 No skill

Not Taught Designated by "X"

- 1 Skill not applicable to client
- 2 Client refused instruction
- 3 Physical and/or mental limitations precluded instruction
- 4 Death
- 5 Adequate skill - no instruction necessary
- 6 Other

<u>SKILL</u>	<u>PRE-INSTRUCTION</u>	<u>POST-INSTRUCTION</u>
--------------	------------------------	-------------------------

TYPING	_____	_____
--------	-------	-------

Comments: _____

BRaille

Alphabet	_____	_____
Grade 1½	_____	_____
Grade 2	_____	_____

Comments: _____

HANDWRITING

- | | |
|------------------------|--|
| _____ Signature | |
| _____ Lists | |
| _____ Letterwriting | |
| _____ Checks & Records | |

Comments: _____

SKILLPRE-INSTRUCTIONPOST-INSTRUCTION

ABACUS

- ☐ Setting Numbers
- ☐ Addition
- ☐ Subtraction
- ☐ Multiplication
- ☐ Division

Comments: _____

TELEPHONE

- ☐ Dialing Numbers
- ☐ System of Recording Numbers

Comments: _____

AUDIO DEVICES - Operation & basic maintenance

- Talking Books
- Cassette Books
- Cassette Tape Recorders
- Audio Accessories

_____	_____
_____	_____
_____	_____

Comments: _____

INTERVIEWER _____

ADL AND HOMEMAKING CHECKLIST OF INSTRUCTIONAL NEEDS AND LEVEL OF ATTAINMENT

Client's Name _____ Date Program Started _____

Total Hours Instruction _____ Date Program Completed _____

Rating Scale:

- 1 Accomplishes tasks with little or no difficulty
- 2 Accomplishes tasks with some difficulty
- 3 Noticeably limited skill
- 4 No skill

Not Taught Designated by "X"

- 1 Skill not applicable to client
- 2 Client refused instruction
- 3 Physical and/or mental limitations precluded instruction
- 4 Death
- 5 Adequate skill - no instruction necessary
- 6 Other

<u>SKILL</u>	<u>PRE-INSTRUCTION</u>	<u>POST-INSTRUCTION</u>
PERSONAL CARE AND GROOMING	_____	_____
_____ Hair care		
_____ Make-up application		
_____ Shaving		
_____ Nail care		
_____ Shoe care		
_____ Lace and tie shoes		
_____ Tie neck tie		
_____ Identify clothing		
_____ Bathroom safety		
EATING SKILLS	_____	_____
_____ Use utensils effectively		
_____ Pour liquids		
_____ Add sugar to drink		
_____ Orientation to plate contents		
_____ Eating in public		
LAUNDRY	_____	_____
_____ Use washer		
_____ Use dryer		
_____ Use laundromat		
_____ Use iron safely		

SKILLPRE-INSTRUCTIONPOST-INSTRUCTION

HOUSEKEEPING SKILLS

- _____ Make bed
- _____ Dust and polish furniture
- _____ Sweep
- _____ Mop
- _____ Use vacuum cleaner
- _____ Clean bathroom and kitchen fixtures

KNOWLEDGE OF NUTRITION

Comments: _____

FOOD PREPARATION

- _____ Shop for groceries
- _____ Label food products
- _____ Set table
- _____ Operate range
- _____ Operate oven
- _____ Use small appliances
- _____ Use knives
- _____ Measuring
- _____ Use recipes
- _____ Wash dishes
- _____ Storage of utensils
- _____ Clean counters

MISCELLANEOUS

- _____ Thread needle
- _____ Sew on buttons and mend
- _____ Identify coins
- _____ System for identification of bills
- _____ Tell time

COMMENTS: _____

INTERVIEWER _____

COMPREHENSIVE SERVICES TO THE ELDERLY BLIND
MOBILITY INSTRUCTIONAL CHECKLIST AND RATING FORM

Client's Name _____ Date Program Started _____

Total Hours Instruction _____ Date Program Completed _____

Months to Completion _____

Rating Scale:

- 1 Accomplishes tasks with little or no difficulty
- 2 Accomplishes tasks with some difficulty
- 3 Noticeably limited skill
- 4 No skill

Not Taught Designated by "X"

- 1 Skill not applicable to client
- 2 Client refused instruction
- 3 Physical and/or mental limitations precluded instruction
- 4 Death
- 5 Adequate skill - no instruction necessary
- 6 Other

<u>SKILL</u>	<u>INITIAL EVALUATION</u>	<u>PRE INSTRUCTION</u>	<u>POST INSTRUCTION</u>	<u>IMPROVEMENT</u>
HUMAN GUIDE TECHNIQUES	_____	_____	_____	_____
<u>Grip</u>				
<u>Arm Position</u>				
<u>Response to Arm Signals</u>				
<u>Stairs</u>				
<u>Curbs</u>				
<u>Seating</u>				
<u>Refusing improper assistance</u>				
<u>Exiting/entering automobiles</u>				
<u>use in daily living</u>				
FAMILIAR INDOOR AREAS (W/O CANE)	_____	_____	_____	_____
<u>Hand & Forearm</u>				
<u>Trailing</u>				
<u>Stairs</u>				
<u>Locates objectives</u>				
<u>Use in Daily Living</u>				
DIAGONAL CANE TECHNIQUE (INDOORS)	_____	_____	_____	_____
<u>Arm Position</u>				
<u>Cane Position</u>				
<u>Trailing</u>				
<u>Stare Technique</u>				
<u>Locates objectives</u>				
<u>Use in Daily Living</u>				

<u>SKILL</u>	<u>INITIAL EVALUATION</u>	<u>PRE INSTRUCTION</u>	<u>POST INSTRUCTION</u>	<u>IMPROVEMENT</u>
TOUCH TECHNIQUE	_____	_____	_____	_____
Posture				
Arm/Hand Position				
Wrists Movement				
Arc Size				
Arc Height				
Cane/Foot Coordination				
Negotiates Obstacles				
Shorelining				
Stair Technique				
Locates Objectives				
Use in Daily Living				
RESIDENTIAL SIDEWALKS	_____	_____	_____	_____
Shorelining				
Maintains Cane Technique				
Drop-Off Detection				
Following Traffic Flow				
Negotiates Obstacles				
Negotiates Walkways				
Negotiates Driveways				
Negotiates Parking Lots				
Direction Changes				
Problem Solving				
Orientation				
Locates Objectives				
Use in Daily Living				
STOP-SIGN CONTROLLED INTERSECTIONS	_____	_____	_____	_____
Approach				
Analysis				
Positioning				
Alignment				
Step-Off				
Crossing				
Recovery Techniques				
Use in Daily Living				
RESIDENTIAL AREAS	_____	_____	_____	_____
Parallels Traffic				
Determines Alternate Routes				
Executes Alternate Routes				
Remains Oriented				
Negotiates Alleys				
Analyzes Intersections				
Problem Solving				
Locates Objectives				
Use in Daily Living				

<u>SKILL</u>	<u>INITIAL EVALUATION</u>	<u>PRE INSTRUCTION</u>	<u>POST INSTRUCTION</u>	<u>IMPROVEMENT</u>
LIGHT-CONTROLLED INTERSECTIONS	_____	_____	_____	_____
Approach				
Analysis				
Positioning				
Alignment				
Localizing Cue Cars				
Starting with Cue Cars				
Straight Crossing				
Use in Daily Living				
SMALL/LARGE BUSINESS AREAS	_____	_____	_____	_____
Negotiates Obstacles				
Negotiates Parking Lots				
Determine Alternate Routes				
Executes Alternate Routes				
Analyzes Intersections				
Negotiates Street Crossings				
Follow Traffic Flow				
Determine & Negotiates Pedestrian Congestion				
Remains Oriented				
Obtains Accurate Pedestrian Directions				
Problem Solving				
Use in Daily Living				
NON-SIDEWALK AREAS	_____	_____	_____	_____
Urban Residential Area/Routes				
Urban Commercial				
Commercial Highways				
Shopping Center				
Suburban Residential				
Multi-lane Highways				
Primary Access Roads				
Secondary Roads				
Back-Country Roads				
Footpaths				
Woods				
Fields				
Small Commercial Stores				
Large Commercial Stores				
Indoor Shopping Malls				
Buses				
Bus Stations				
Train Stations				
Airports				
Escalators				
Elevators				
Revolving Doors				

APPENDIX E
WEST VIRGINIA DIVISION OF VOCATIONAL
REHABILITATION FORMS

TERR NR

SURVEY INTERVIEW

DIRECTIONS TO CLIENT'S RESIDENCE

TELEPHONE NR

SOURCE OF REFERRAL

HAS CLIENT RECEIVED REHABILITATION SERVICES PREVIOUSLY?

YES

NO

FROM WHAT STATE OR AGENCY?

WAS CLIENT REHABILITATED?

YES

NO

SERVICES RECEIVED

DATE & ORIGIN OF IMPAIRMENT AS REPORTED BY CLIENT

WORK LIMITATIONS AS REPORTED BY CLIENT

TREATMENT CLIENT REPORTS HAVING RECEIVED FOR IMPAIRMENT

TYPE TREATMENT

WHERE RECEIVED

APPROXIMATE DATES

FREQUENCY IF NOW BEING TREATED

SUMMARY OF CLIENT'S PRESENT HEALTH
(INCLUDE TYPES & FREQUENCIES OF ILLNESSES)NAME & ADDRESS OF CLIENT'S
CURRENT OR LATEST PHYSICIAN

TYPE APPLIANCE CLIENT USES

DATE FITTED

CONDITION

MANUFACTURER

HOW WAS APPLIANCE PAID FOR?

WILL CLIENT NEED
NEW APPLIANCE?

YES

NO

DOES CLIENT HAVE
VENDOR PREFERENCE?

YES

NO

IF YES, SPECIFY VENDOR

HIGHEST YEAR
COLLEGE COMPLETED

DIPLOMA?

YES

NO

HIGHEST YEAR
COLLEGE COMPLETED

WHAT DEGREE?

SUMMARY OF CLIENT'S EDUCATION & TRAINING (LATEST TO EARLIEST)

SCHOOL & ADDRESS

APPROXIMATE DATES

COURSE

SUBJECT LIKED BEST

SUBJECT LIKED LEAST

CAN CLIENT
READ?

YES

NO

CAN CLIENT
WRITE?

YES

NO

DI STATUS CODE

● Not an Applicant 0
 ● Applicant: Allowed Benefits..... 1
 ● Applicant: Denied Benefits..... 2

● Applicant: Status of
 Application Pending 3
 ● Not Known If an Applicant..... 4
 ● Benefits Discontinued
 or Terminated 5



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General assistance only (GA) ... 5
 AFDC combination with
 other type(s) ... 6
 Any other combination of
 above types ... 7
 Type(s) not known ... 8
 PA received between referral
 and closure only ... 9
 Not available ... y

PUBLIC ASSISTANCE TYPE CODE
 None 0
 Old-age assistance (OAA) 1
 Aid to the blind (AB) 2
 Aid to Permanently and
 totally disabled 3
 Aid to families with dependent
 children only (AFDC) 4

Agency-Managed BEP 4
 Homemaker 5
 Unpaid Family Worker 6
 Not Working, Student 7
 Trainee or Worker Non-
 Competitive Labor Market 9

WORK STATUS CODE
 Wage or Salaried Worker,
 Competitive Labor Market 1
 Wage or Salaried Worker,
 Sheltered Workshop 2
 Self-Employed, Except BEP 3

MARITAL STATUS CODE
 Married 1
 Widowed 2
 Divorced 3
 Separated 4
 Never Married 5

SOCIAL SECURITY CLAIM TYPE CODE

- Disabled wage earned (DiB)----- 1
- Claim for disabled child benefits based on account number of retired or deceased wage earner (CDB-OA)----- 2
- Claim for disabled child benefits based on account number of wage earner currently entitled to disability benefits (CDB-DI)----- 3
- Claim for disabled widow, widower, or surviving divorced wife benefits based on account number of deceased wage earner (DWB)-----

SUMMARY OF CLIENT'S EMPLOYMENT RECORD (LATEST TO EARLIEST)												
EMPLOYER & ADDRESS			JOB & WAGES			DATES		REASON FOR LEAVING				
CURRENT WORK STATUS?			IS CLIENT REGISTERED W/EMP SVC?		YES	NO	CAN CLIENT DRIVE?		YES	NO	SPECIAL LICENSES OR CERTIFICATES	
HAS CLIENT TRIED TO FIND WORK?		YES	NO	IF YES, PROVIDE DETAILS								
HAS CLIENT ANY JOB PROSPECTS?		YES	NO	IF YES, PROVIDE DETAILS								
VOCATIONAL CHOICE(S) & REASON(S)												
HOBBIES & SPECIAL SKILLS (INCLUDE MILITARY)												
1ST REFERENCE			REFERENCES' NAME, ADDRESS & TELEPHONE NR						2ND REFERENCE			
COMPOSITION OF CLIENT'S HOUSEHOLD (USE * FOR HEAD OF HOUSEHOLD)												
NAME			AGE		RELATIONSHIP			WHERE EMPLOYED				
			IS CLIENT A DEPENDENT?		YES	NO	NR IN CLIENT'S FAMILY GROUP (INCL CLIENT)			CLIENT'S PRIMARY SOURCE OF SUPPORT†		
IS CLIENT COVERED BY PRIVATE HOSPITALIZATION INSURANCE?			YES	NO	SPECIFY COMPANY & POLICY NR					TOTAL MONTHLY FAMILY INCOME		
IS CLIENT COVERED BY PUBLIC HOSPITALIZATION INSURANCE?			YES	NO	SPECIFY PROGRAM			WELFARE MEDICAL CARD?		YES	NO	
YES		NO	DATE STARTED				AMT/MONTH		TYPE PA GRANT†			
YES		NO	AMT/MONTH			TYPE SOC SEC CLAIM†			SSDI STATUS AT REFERRAL†			
IS CLIENT RECEIVING COMPENSATION GRANT?			YES	NO	AMT/WK		CLAIM NR		EMPLOYER CLAIM FILED AGAINST			
IS CLIENT RECEIVING UNEMPLOYMENT INSURANCE?			YES	NO	BEGINNING DATE				ENDING DATE			
IS CLIENT A VETERAN?		YES	NO	BRANCH OF SVC		SERVICE NR		DATES OF ACTIVE DUTY				
VA CLAIM NR			IF CLIENT HAS SERVICE-CONNECTED DISABILITY, DESCRIBE									
INTERVIEW DATE			INTERVIEW PLACE			COUNSELOR'S SIGNATURE						

Use appropriate code number from codes printed on this form.

- Disability or sickness benefits (private insurance); savings, other sources..... 10
- Not available..... Y Y
- Other disability, sickness, benefits (private insurance); savings, other sources..... 08
- Unemployment benefits..... 09
- Private insurance benefits..... 09
- Public assistance, without assistance of family..... 04
- Public institution..... 05
- Tax-supported..... 06
- Workmen's compensation..... 07
- Disability insurance benefits..... 08
- Private insurance benefits..... 09
- Source of support code: Current earnings, interest, dividends, only..... 00
- Family and friends..... 01
- Private relief agency..... 02
- Religious or fraternal organization..... 03
- Party with federal funds..... 03

APPLICATION FOR REHABILITATION SERVICES

WHAT VOCATIONAL REHABILITATION IS. Vocational rehabilitation is a service of the state and federal governments that prepares physically and mentally handicapped persons for gainful employment.

ELIGIBILITY REQUIREMENTS. To be eligible for vocational rehabilitation, the applicant, in the judgment of the Division of Vocational Rehabilitation, must:

- Have a physical or mental disability;
- Be unable, as the result of that disability, to get or hold a gainful job; and,
- Have a reasonable expectation of getting, or holding, a gainful job as the result of having received vocational rehabilitation services.

No person shall be denied services, or otherwise discriminated against, on the ground of race, color, or national origin.

WHAT SERVICES MAY BE PROVIDED. Rehabilitation services are provided on an individual basis, with each person receiving the exact services he is found to need. Among the services the individual may receive are:

- Diagnostic and related services.
- Counseling.
- Physical restoration.
- Rehabilitation training.
- Books and training supplies.
- Maintenance.
- In cases where the Division is unable to determine through regular diagnostic means whether an applicant has rehabilitation potential, the applicant may be provided *extended evaluation services* to aid in determination of rehabilitation potential.
- Placement.
- Tools, equipment, initial stocks, and supplies.
- Management and supervisory services for those placed in small business enterprises.
- Transportation.
- Occupational licenses.
- Reader services for the blind.
- Interpreter services for the deaf.
- Other services as required.

CONFIDENTIALITY OF INFORMATION. All personal facts and other information obtained by the Division from, or concerning, a person applying for, or receiving, rehabilitation services will be regarded as confidential and will be used for official purposes only.

RIGHT OF APPEAL. Any applicant found ineligible for rehabilitation services shall be notified in writing. Any applicant for, or recipient of, rehabilitation services who is dissatisfied with any decision of the Division with regard to the denial, or furnishing, of any services shall have the right of appeal. The counselor concerned shall be obligated to provide the applicant or recipient full instructions for filing such appeal. Any applicant for, or recipient of, services from the Division who believes he has been discriminated against because of his race, color, or national origin, may file a written complaint with the Division or with the federal Department of Health, Education, and Welfare.

TO BE COMPLETED BY APPLICANT, OR, IF A MINOR, BY PARENT OR GUARDIAN. IF APPLICANT IS INCOMPETENT, TO BE COMPLETED BY PARENT, GUARDIAN, SPOUSE, OR NEXT-OF-KIN.

☐	I understand the above explanation and hereby apply for vocational rehabilitation services.	
	APPLICANT	PARENT OR GUARDIAN
SIGNATURE		
STREET ADDRESS OR POST OFFICE BOX		
CITY, STATE, ZIP CODE		
DATE		
TO BE COMPLETED BY COUNSELOR OR SUPERVISOR		
☐	SIGNATURE	DATE
I hereby acknowledge receipt of this application.		

INSTRUCTIONS. Prepare in duplicate. Use blue copy for carbon. File white original in case folder; give blue carbon to applicant. This form must be completed before any rehabilitation service may be provided.

*Before signing, counselor will be sure that case folder is documented fully to support certificate. Such documentation will include medical reports, evaluation reports, and other materials required to support certificate.

CERTIFICATE OF ACCEPTABILITY (FOR EXTENDED EVALUATION)

CHECK SSDI STATUS	0	1	2	3	4	5

THE FOLLOWING APPLY TO THE APPLICANT NAMED ON THE FRONT OF THIS FORM:

YES	NO	
☐	☐	He has a physical or mental disability.
☐	☐	He has a substantial handicap to employment resulting from his disability.
☐	☐	The agency is unable at this date to determine whether there is a reasonable expectation that vocational rehabilitation services may render him fit to engage in a gainful occupation.

Therefore, with respect to extended evaluation, I hereby certify that the applicant is:

☐ ACCEPTABLE ☐ NOT ACCEPTABLE

COUNSELOR'S STATEMENT

COUNSELOR'S SIGNATURE*

DATE

CERTIFICATE OF ELIGIBILITY (FOR REHABILITATION SERVICES)

CHECK SSDI STATUS	0	1	2	3	4	5

THE FOLLOWING APPLY TO THE APPLICANT NAMED ON THE FRONT OF THIS FORM:

YES	NO	
☐	☐	He has a physical or mental disability.
☐	☐	He has a substantial handicap to employment resulting from his disability.
☐	☐	There is a reasonable expectation that vocational rehabilitation services may render him fit to engage in a gainful occupation.

Therefore, with respect to rehabilitation services, I hereby certify that the applicant is:

☐ ELIGIBLE ☐ INELIGIBLE

COUNSELOR'S STATEMENT

COUNSELOR'S SIGNATURE*

DATE

CERTIFICATE OF SELECTION (FOR TRUST FUND SERVICES)

CHECK SSDI STATUS	0	1	2	3	4	5

THE FOLLOWING APPLY TO THE APPLICANT NAMED ON THE FRONT OF THIS FORM:

YES	NO	
☐	☐	He is a Social Security Disability Insurance (SSDI) beneficiary.
☐	☐	He has a disabling physical or mental impairment which is not so rapidly progressive as to outrun the effect of vocational rehabilitation services or to preclude his restoration to productive activity.
☐	☐	The disabling effect of his impairment without the rehabilitation services planned is expected to remain at a level of severity which would result in continued payment of SSDI benefits.
☐	☐	There is a reasonable expectation that provision of such rehabilitation services will result in his restoration to productive activity.
☐	☐	The reasonable predictable period of productive work activity is of sufficient duration that the benefits to be saved and the contributions which would be paid into the Trust Fund from his future earnings would offset the cost of rehabilitation services planned to be paid for from the Trust Fund.

Therefore, with respect to Trust Fund services, I hereby certify that the applicant is:

☐ SELECTED ☐ NOT SELECTED

COUNSELOR'S STATEMENT

COUNSELOR'S SIGNATURE*

DATE

SSDI STATUS CODE
 0 Not an Applicant
 1 Applicant: Allowing Benefits
 2 Applicant: Denial of Benefits
 3 Applicant: Status of Application Pending
 4 Not Known if an Applicant
 5 Applicant: Discontinued

Replaces DM/DVB-1, General Medical Examination Report, dated Feb 78a, stocks of which will be salvaged.

GENERAL MEDICAL EVALUATION (Confidential)

TO BE COMPLETED BY AGENCY

CLIENT'S NAME (LAST/FIRST/MI) & ADDRESS (include ZIP)

SEND REPORT TO:

DC
EC NRDATE OF
BIRTH☐ MEDICAL EXAMINATION
IN PAST 12 MONTHS: ☐ SSA ☐ DOW☐ CURRENTLY UNDER
PHYSICIAN'S CARE WHO☐ DVR ☐ WCC ☐ OTHER

FOR WHAT

CLIENT'S STATEMENT OF DISABILITY, DURATION, AND HOW HANDICAPPED FOR WORK:

YES	NO	MEDICAL HISTORY
☐	☐	HOSPITAL, SURGERY
☐	☐	HEART, CHEST PAIN, HIGH BLOOD PRESSURE, SHORT OF BREATH
☐	☐	LUNGS, ASTHMA, EMPHYSEMA
☐	☐	HABITUAL COUGH, BLOOD, X-RAY, STOMACH, ULCER, GALL BLADDER
☐	☐	KIDNEY, ALBUMIN, SUGAR, BLOOD
☐	☐	FEMALE TROUBLE
☐	☐	CANCER
☐	☐	EYES, VISION, EARS, HEARING
☐	☐	SEIZURES, FAINING, HEADACHE
☐	☐	STROKE, PARALYSIS
☐	☐	PSYCHIATRIC, NERVOUS
☐	☐	BACK, ARTHRITIS, EXTREMITIES
☐	☐	DIABETES, THYROID
☐	☐	ALCOHOLISM, DRUGS
☐	☐	WEIGHT LOSS (10 LBS. IN 3 MOS.)
☐	☐	SYPHILIS
☐	☐	OTHER (SPECIFY)

REMARKS AND SPECIFIC
REQUESTS TO EXAMINER:

MEDICAL HISTORY DETAILS: WHAT, WHEN, CURRENT STATUS

TO BE COMPLETED BY NURSE OR PHYSICIAN'S STAFF

DISTANT VISION	RIGHT	LEFT	NEAR VISION (JAEGER)	RIGHT	LEFT	HEIGHT	WEIGHT	BLOOD PRESSURE
WITHOUT GLASSES			WITHOUT GLASSES			URINALYSIS:	ALBUMIN	SUGAR
WITH GLASSES			WITH GLASSES			SEROLOGY (SYPHILIS), IF INDICATED:		
						☐ RESULT		
						☐ BLOOD DRAWN; WILL FORWARD REPORT		

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over

PHYSICIAN EVALUATION

This evaluation is needed to determine the degree of impairment so that the rehabilitation counselor may determine eligibility, an employment objective, and a plan of services. Please review with the client all positive responses to the screening history recorded on the front of this form, and record additional

history, findings, and your opinion whether they have current significance or need further study. Please note any discrepancy between apparent medical status and the client's statement of handicap. Please discuss your findings with the client.

NORMAL	ABNORMAL		COMPLAINT/PRESENT ILLNESS
		PHYSICAL EXAMINATION	
		EYES	
		EARS, NOSE, THROAT	
		MOUTH, TEETH	
		NECK, THYROID	
		LYMPHATIC SYSTEM	
		BREASTS, AXILLAE	
		LUNGS, CHEST	
		HEART	
		ABDOMEN, HERNIA	
		GENITALIA, PELVIC	
		ANO-RECTAL	
		LIMBS, JOINTS, SPINE	
		EDEMA, VARICOSE VEINS	
		NEUROLOGICAL, GAIT	
		PSYCHIATRIC	
		GENERAL APPEARANCE	

DIAGNOSES (MAJOR, MINOR)

FUNCTIONAL LIMITATIONS,
DEGREE, RESTRICTIONS:
(e.g., lifting, heavy exercise,
stamina, standing, walking,
climbing stairs, driving)

WORK SITUATIONS
HAZARDOUS TO HEALTH
(e.g., dust, exertion, swing
shift)

PROGNOSIS
(Stable, progressive; estimate
future function and timetable)

ADDITIONAL STUDIES,
CONSULTATIONS

TREATMENT RECOMMENDED

REMARKS

FINDINGS AND RECOMMENDATIONS DISCUSSED WITH CLIENT? ☐ YES ☐ NO

EXAMINING
PHYSICIAN'S
SIGNATURE

DATE

REPORT OF VISUAL EXAMINATION

TO BE COMPLETED BY COUNSELOR*

CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR

AUTHORIZATION NR

IND REPORT TO:

RECORD ANY
MEDICATION
CLIENT TAKING
CURRENTLY,
ANY CHRONIC
DISEASE CLIENT
HAS, AND IF
KNOWN, GENERAL
NATURE OF CLIENT'S
EMPLOYABLE JOB
OBJECTIVE

HAS CLIENT EVER WORN GLASSES AT ANY TIME?
DOES CLIENT PRESENTLY WEAR GLASSES?

YES ☐ NO ☐
YES ☐ NO ☐

DOES CLIENT HAVE DIABETES?
IS CLIENT'S HEARING IMPAIRED?

YES ☐ NO ☐
YES ☐ NO ☐

COUNSELOR'S
REMARKS OR
QUESTIONS
TO EXAMINER

TO BE COMPLETED BY EXAMINER

TO EXAMINER: This examination is needed to determine whether there is an impairment, the extent of disability caused by that impairment, whether that impairment can be improved medically, and the prognosis (probabilities and timetable), all of which will be used to formulate an appropriate vocational rehabilitation program for the client. The content of this report is confidential, except that it may be disclosed to the client and to other physicians participating in evaluation and treatment. A copy of your notes to your case record covering the foregoing points, rather than this form, may be used for your report. Return the completed original to this agency and retain the copy if you wish.

MEDICAL
HISTORY
RELEVANT
TO EYES

VISUAL ACUITY: DISTANCE

RIGHT

LEFT

BINOCULAR

VISUAL ACUITY: NEAR VISION

RIGHT

LEFT

BINOCULAR

RECOMMENDED REFRACTION:

RIGHT

LEFT

WITHOUT GLASSES

WITH PRESENT GLASSES

WITH BEST CORRECTION

SPHERE

CYLINDER

AXIS

ADDS (BIFOCAL)

CYCLOPLEGIC (DROPS) USED? YES ☐ NO ☐

OVER

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*Send examiner original and one copy. Attach copies of other medical information on hand.

NORMAL		ABNORMAL		DETAILS OF ABNORMALITY
		COLOR PERCEPTION (Color blind for what colors?)		
		USEFUL BINOCULAR VISION (Stereopsis)		
		GROSS EXTERNAL EXAMINATION		
		TUNING FORK (Optional) (Intraocular pressure)		
		MUSCLE BALANCE (Gross only unless evidence of abnormality)		
		VISUAL FIELDS (Gross only unless evidence of abnormality)		
		OPHTHALMOSCOPY		
		SLIT LAMP MICROSCOPY [Optional]		
		OTHER (Specify)		

DIAGNOSIS:

- ☐ RIGHT
☐ LEFT
☐ BOTH
☐ ACUTE ☐ CHRONIC ☐ STABLE ☐ UNSTABLE
☐ PROGRESSIVE (Expected rate)

FURTHER TESTS AND/OR CONSULTATION NEEDED
TREATMENT (Specify)
☐ GLASSES? IF SO, ATTACH PRESCRIPTION

PRECAUTIONS (Activities and work to be avoided or limited)
OTHER REMARKS

 WERE REPORT/FINDINGS
DISCUSSED WITH CLIENT?

 YES ☐
NO ☐

DATE

EXAMINER'S SIGNATURE

REQUEST FOR INFORMATION

(Party from Whom Information Requested)

TO:

(Counselor's Name, Terr Nr & Address)

FROM:

(Client's Name [Last/First/MI], Soc Sec Nr & Address)

SUBJECT:

The above-named client has applied to the Division of Vocational Rehabilitation for rehabilitation services. The information described below is requested* from you for the purposes of assisting us in determining whether the client is eligible for services, and if so, in determining the specific rehabilitation services he will need to become employable. The client's authorization for you to release the requested information is elsewhere on this form. The Division of Vocational Rehabilitation will keep the requested information confidential, will use it only for the purposes of the client's rehabilitation, and will not release it further.

*If there is a charge involved for providing the requested information, attached is our Authorization for you to invoice the Division of Vocational Rehabilitation.

REQUESTING COUNSELOR'S SIGNATURE & DATE

CLIENT'S AUTHORIZATION FOR RELEASE OF REQUESTED INFORMATION

I, the above-named client, have applied to the Division of Vocational Rehabilitation for rehabilitation services. I hereby authorize the "party from whom information requested," above, to release to the Division of Vocational Rehabilitation the information requested above. I give this authorization with the express understanding that the Division of Vocational Rehabilitation will keep the requested information confidential, will use it only for the purposes of my rehabilitation, and will not release it further.

CLIENT'S SIGNATURE & DATE*

WITNESS' SIGNATURE & DATE

*If the client legally cannot authorize release of requested information because of being a minor or incompetent or for any other reason, the authorization must be signed by an individual legally-empowered to do so. In such a case, the "relationship to client of person signing authorization" and "reason why client cannot sign authorization" blocks, opposite, must be completed.

RELATIONSHIP TO CLIENT OF PERSON SIGNING AUTHORIZATION

REASON WHY CLIENT CANNOT SIGN AUTHORIZATION

INDIVIDUALIZED WRITTEN REHABILITATION PROGRAM		CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR		INITIAL PROGRAM	
				AMENDMENT NR	

1. YOUR VOCATIONAL GOAL You have been found acceptable for extended evaluation. You will receive appropriate vocational rehabilitation services, as determined jointly by you and your counselor, to find out whether vocational rehabilitation services can help you get or hold a job. You have been found eligible for vocational rehabilitation services. You will receive appropriate vocational rehabilitation services, as determined jointly by you and your counselor, to prepare you for and place you in the job or job range entered below, your vocational goal. You have been determined to be rehabilitated. You will receive appropriate vocational rehabilitation services, as determined jointly by you and your counselor, to maintain your employment	2. GENERAL COURSE OF YOUR PROGRAM. Below are the intermediate objectives that must be accomplished to meet your vocational goal. The numbers show the order in which the objectives must be met. <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width: 80%;">Determine whether vocational rehabilitation services can help you get or hold a job, by providing you appropriate extended evaluation services</td> <td style="width: 20%;">ESTIMATED COMPLETION DATE</td> </tr> <tr> <td>Help you select a suitable job, your vocational goal</td> <td></td> </tr> <tr> <td>Remove your disability or reduce its effects</td> <td></td> </tr> <tr> <td>Train you for work in a suitable job, your vocational goal</td> <td></td> </tr> <tr> <td>Provide you intensive counseling and guidance</td> <td></td> </tr> <tr> <td>Place you in a suitable job, your vocational goal</td> <td></td> </tr> <tr> <td>Provide you post-employment services</td> <td></td> </tr> </table>	Determine whether vocational rehabilitation services can help you get or hold a job, by providing you appropriate extended evaluation services	ESTIMATED COMPLETION DATE	Help you select a suitable job, your vocational goal		Remove your disability or reduce its effects		Train you for work in a suitable job, your vocational goal		Provide you intensive counseling and guidance		Place you in a suitable job, your vocational goal		Provide you post-employment services	
Determine whether vocational rehabilitation services can help you get or hold a job, by providing you appropriate extended evaluation services	ESTIMATED COMPLETION DATE														
Help you select a suitable job, your vocational goal															
Remove your disability or reduce its effects															
Train you for work in a suitable job, your vocational goal															
Provide you intensive counseling and guidance															
Place you in a suitable job, your vocational goal															
Provide you post-employment services															

3. SERVICES YOU WILL RECEIVE. Below are the general types of vocational rehabilitation services that you will receive to reach your vocational goal.		
SERVICE	EST. COMP. DATE	DETAILS
Diagnostic and Related		
Counseling and Guidance		
Physical/Mental Restoration		
Rehabilitation Training		
Maintenance		
Transportation		
Tools/Equipment/Stocks		
Services for Family Members		
Placement		
Other		

4. PAYMENT FOR SERVICES. Based on information you provided about your financial condition, here are the details of payment for the services that you will receive:

☐ You are expected to pay nothing for the services you receive, based on your current financial condition.

☐ You are expected to pay \$ _____ per month for _____ months. Payment will be by check to the "Division of Vocational Rehabilitation." The first payment is due by the last day of _____, and the final payment by the last day of _____

☐ Other payment arrangements: _____

5. REVIEW AND EVALUATION OF YOUR PROGRESS TOWARD GOALS AND OBJECTIVES

6. YOUR VIEWS ABOUT YOUR PROGRAM. I, the client (or his representative), understand the general terms and conditions of my program as printed on the back of this form. Further, I understand the specific goals, objectives, services, and other provisions of my program as explained to me by my counselor. My views are:

☐ I agree fully with the program. I understand that it is subject to change, based on a review by my counselor's supervisors. I authorize my counselor to proceed with the program.

☐ I disagree completely with the program. _____ I request an administrative review.

☐ I disagree with the points listed below. However, I authorize my counselor to proceed with the program. _____

7. REMARKS

8. CLIENT'S SIGNATURE & DATE	9. COUNSELOR'S SIGNATURE & DATE	10. SUPERVISOR'S SIGNATURE & DATE
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**INDIVIDUALIZED WRITTEN
REHABILITATION PROGRAM**

CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR

REHABILITATED CLOSURE (STATUS 26) STATEMENT

TYPE OCCUPATION

LENGTH OF TIME
CLIENT HAS WORKED

EMPLOYER'S NAME & ADDRESS

STARTING PAY

RATIONALE FOR DETERMINATION THAT CLIENT HAS MADE SATISFACTORY VOCATIONAL ADJUSTMENT

COUNSELOR'S SIGNATURE & DATE

NEED FOR POST-EMPLOYMENT SERVICES

COUNSELOR'S SIGNATURE & DATE

REVIEW DATE

NON-REHABILITATED CLOSURE (STATUS 08, 28, OR 30, AMENDMENT)

CLIENT'S STATEMENT

CLIENT'S SIGNATURE & DATE

COUNSELOR'S JUSTIFICATION

COUNSELOR'S SIGNATURE & DATE

ANNUAL REVIEW DATE

TERMINATION OF POST-EMPLOYMENT SERVICES

COUNSELOR'S JUSTIFICATION

OCCUPATION AT TERMINATION

EMPLOYER'S NAME & ADDRESS

COUNSELOR'S SIGNATURE & DATE

REMARKS (USE IF ADDITIONAL SPACE IS NEEDED FOR ABOVE ENTRIES)

INITIAL PROGRAM OR AMENDMENT SUMMARY

INITIAL PROGRAM

AMENDMENT NR

CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR

TERR

AGE

SEX

STAT

EXTENDED EVALUATION

IN-SERVICE

POST-EMPLOYMENT

PRIMARY DISABILITY

CODE

SECONDARY DISABILITY

CODE

RATIONALE FOR VOCATIONAL GOAL. Describe basis on which vocational goal determined. If amended vocational goal, state reason(s) for change. If possible, explain client's need for such services. How did you and client arrive at this vocational goal?

JUSTIFICATION OF PLANNED SERVICES. Explain how planned services will contribute to client's attainment of vocational goal. How did you and client choose each of the planned services as outlined in Block 3 of WVDVR-90?

USE OF BENEFITS AVAILABLE TO CLIENT. Explain how any third-party resources will be used to pay for or provide services for client.

PLACEMENT PROSPECTS AND PLANS. Give estimate of prospects for client's placement in vocational goal. Summarize placement plans.

REMARKS. Use to amplify or clarify any of above points and/or to provide other pertinent information.

Replaces edition of 01 Jul 75e, stocks of which will be used until exhausted.

DETAILS OF SERVICES TO BE PROVIDED				INITIAL PROGRAM		EXTENDED EVALUATION			
				AMENDMENT NR _____		IN-SERVICE			
						POST-EMPLOYMENT			
CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR								TERR	STAT
SERVICE									
VENDOR				AMOUNT TO BE PAID BY					
				NR UNITS	UNIT COST	TOTAL COST	CLIENT	OTHER	AGENCY
FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
VENDOR									
FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
VENDOR									
FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
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FROM (DATE)	TO (DATE)	NEED?							
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FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
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FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
VENDOR									
FROM (DATE)	TO (DATE)	NEED?							
SERVICE									
VENDOR									
FROM (DATE)	TO (DATE)	NEED?							
COUNSELOR'S SIGNATURE & DATE			SUPERVISOR'S SIGNATURE & DATE			SUMMARY			

CASE DEVELOPMENT LOG		CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR	PAGE NR
DATE	ST	NARRATIVE	
	02	CERTIFICATE OF ELIGIBILITY INELIGIBILITY ACCEPTABILITY (Line out inapplicable terms) 1. a. The client has the following primary disability, as substantiated by documents in Section L-2, Medical Data, of this case folder. Pri Dis _____ b. That disability ☐ imposes ☐ does not impose a substantial handicap to the client's employment because: 2. a. As justified below, there is a reasonable expectation that rehabilitation services ☐ will ☐ will not benefit the client in terms of employability. b. ☐ As explained below, based on the findings of the preliminary diagnostic study, it cannot be determined whether rehabilitation services will benefit the client in terms of employability. JUSTIFICATION/EXPLANATION: Therefore, the client is this date certified ☐ eligible ☐ not eligible for rehabilitation services OR ☐ acceptable for extended evaluation.	

INSTRUCTIONS. This form will be used solely as a chronological record, in brief narrative form, of development of the case. It will not be used as an intra-agency memorandum.

1. PAGE NUMBER. Enter in sequence. When filed in the case folder, the greatest page number will be on top.

2. DATE. Enter the date on which the entry is made, not the effective date of the event described. Use numerical dates, such as 7-10-70. Immediately below the date enter the initials of the person responsible for

having the entry made.

3. STATUS (ST). Enter the status the client is in at the close of business on the date of entry. In change of status entries, this always will mean the status into which changed.

4. NARRATIVE. Enter in sufficient detail for clear understanding. When an entry contains information that is in greater detail elsewhere in the case folder, make a reference to the appropriate document, such as "See WVDVR-76, dated 7-3-70."

CASE DEVELOPMENT LOG		CLIENT'S NAME (LAST/FIRST/MI) & SOC SEC NR	PAGE NR
DATE	ST	NARRATIVE	
		CERTIFICATE OF SEVERE DISABILITY ☐ The client IS NOT severely disabled. ☐ The client IS severely disabled because: ☐ His primary disabling condition, entered below, is among the qualifying conditions listed in Section 2100, WVDVR Manual. _____ (Primary Disabling Condition) _____ (Code) ☐ He is, or was as of _____, receiving SSDI benefits. See the form filed in Section R-1, Case Service Forms, of this case folder. ☐ He is, or was as of _____, receiving SSI benefits. See the form filed in Section R-1, Case Service Forms, of this case folder. ☐ Of the functional limitation factors listed in Section 2100, WVDVR Manual, he meets the following:	

INSTRUCTIONS. This form will be used solely as a chronological record, in brief narrative form, of development of the case. It will not be used as an intra-agency memorandum.

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APPENDIX F
COMMUNITY RESOURCES
and
STAFF TRAINING

COMMUNITY RESOURCES

Kanawha County

Division of Vocational Rehabilitation Counselor for the Blind
Welfare Area Office
Welfare State Office Adult Services Unit
Charleston Housing Authority
West Virginia Library Commission
Charleston Area Medical Center - General Division Social Services Unit
Commission on Aging
Kanawha Day Center for the Elderly
Lawrence Frankel Preventicare Program
Senior Services of Kanawha Valley
Visiting Nurses
Meals on Wheels
Lions Club Sight Foundation
Medical Eye Bank of West Virginia
Veteran's Affairs
All Nursing Homes
Hilltop Home for the Elderly
Operation "Good Morning" - City of Charleston
All Churches
All Optometrists and Ophthalmologists
Tenant Services workers at Elderly High-Rises: Carroll Terrace,
Lee Terrace, Jarrett Terrace, Villager Apartments, Parkland Terrace
Kanawha County Parks and Recreation Commission
Kanawha County Federation of the Blind

Cabell County

Division of Vocational Rehabilitation Counselor for the Blind
Welfare Area Office
Southwestern Community Action
Senior Citizens Center
Senior Personal Service Program
Cabell County Recreation Department
Cabell County Federation of the Blind
Cabell County Housing Authority
Information and Referral Bureau
Cabell County Homemaker Planning Committee

Wood County

Division of Vocational Rehabilitation Counselor for the Blind
Welfare Area Office
Community Action
Associated Blind of Parkersburg, Inc.
West Virginia University Extension Services
We Care, Inc.
Parkersburg Health Department
Parkersburg Housing Authority
Senior Citizens Center
Regional Library
St. Joseph Hospital Speech & Hearing Center

STAFF TRAINING

1. Biology of Aging, University of Michigan, Ann Arbor, Michigan
2. Residual Vision as Related to Mobility, Woodrow Wilson Rehabilitation Center, Fishersville, Virginia.
3. Components of a Complete Visual Examination, Walter S. Ramsey, O. D., Charleston, West Virginia
4. Institute on Gerontology, West Virginia University Medical Center, In-Service Education, Charleston, West Virginia
5. West Virginia Division of Vocational Rehabilitation Staff Conference, Jacksons Mill, Weston, West Virginia
6. Optical Aids Workshop, Thomas Griffith, O. D., West Virginia Rehabilitation Center, Institute, West Virginia
7. National Rehabilitation Association Mid-Atlantic Regional Conference, Norfolk, Virginia.
8. Rehabilitation of the Visually Impaired, Temple University Medical Center, Philadelphia, Pennsylvania
9. Annual Senior Citizens Conference, West Virginia Commission on Aging, Jacksons Mill, Weston, West Virginia
10. Seminar on Diabetes, Charleston Area Medical Center, General Division, Charleston, West Virginia
11. Communications Training, Greater Pittsburgh Guild for the Blind, Bridgeville, Pennsylvania
12. Seminar on Reality Therapy, William Glasser, M. D., Morris Harvey College, Charleston, West Virginia
13. Workshop on Reminiscing, Priscilla Ebersole, R. N., West Virginia University Medical Center, Charleston Division and Mental Health Service Providers of Region III, Charleston, West Virginia